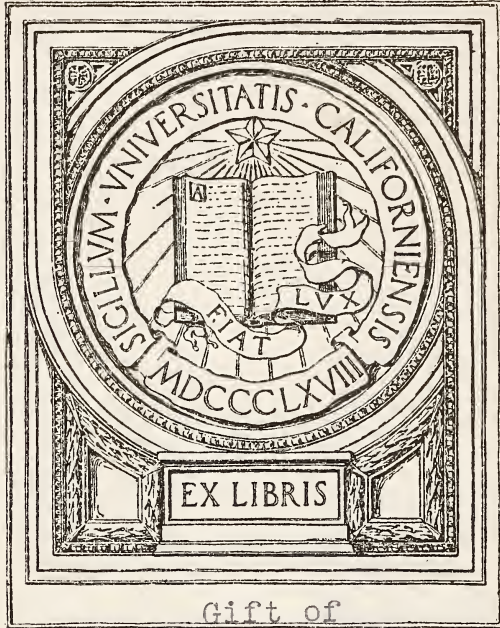




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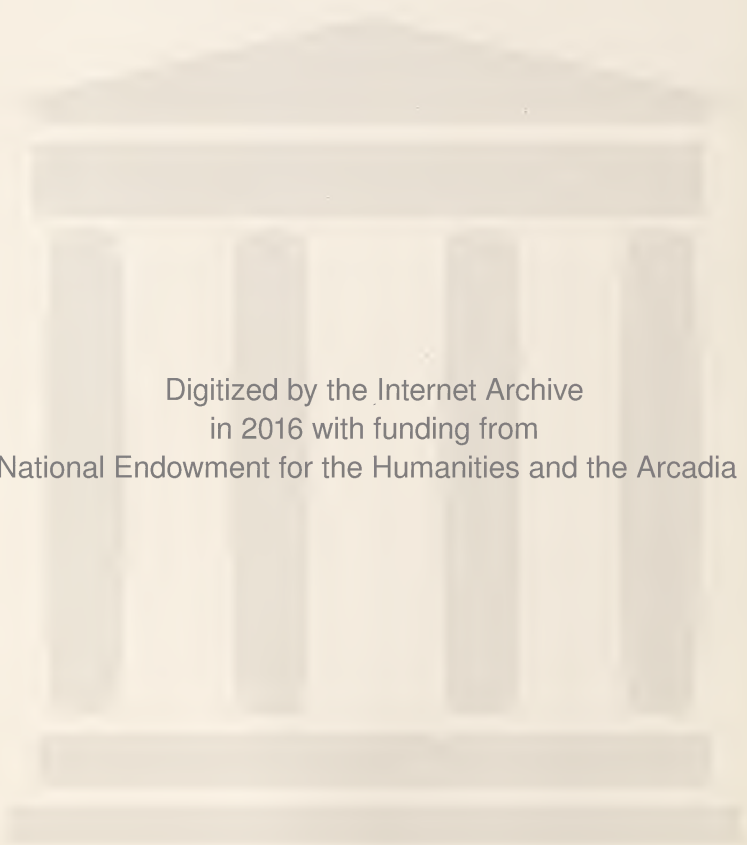


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Vol. 73

JULY, 1920

No. 1

# New Orleans Medical

AND

# Surgical Journal

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INCORPORATING

AMERICAN JOURNAL OF TROPICAL DISEASES AND PREVENTIVE MEDICINE

EDITORS:—Chas. Chassaingnac, M. D., and Isadore Dyer, M. D.

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Vol. 73

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No. 1

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## EDITORIAL

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### THE CORRECT PLACE OF THE LOUISIANA LEPER HOME.

In furthering the transfer of the Louisiana Leper Home to the U. S. Federal Government, Governor Parker, we hope unwittingly, has slurred the historical record of the Home, and the impression he may have created needs to be obliterated. In saying that under Federal control "these poor unfortunates would be handled along the line of most modern and scientific methods," Governor Parker has overlooked more than twenty-five years of service in this State.

The Louisiana Leper Home was established in 1894.

It was the first institution devoted to the care and treatment of leprosy in the United States.

It was the first institution in the United States to establish the cure of leprosy.

It determined the use of Chaulmoogra oil in its crudest liquid form as *the* treatment of the disease. As long ago as 1896, the

essential oil of Chaulmooga was essayed in treating lepers. This is important as bearing on the recent reports on the use of "ethyl ester" which has been derived from this essential oil and which now seems efficacious in treating leprosy.

When the U. S. P. H. S. established its colonization of lepers in the Philippines, the methods of the Louisiana Leper Home were studied and employed.

The work of the Louisiana Leper Home has had world wide acceptance as being modern and progressive. No evidence before the Senate Committee in 1916 militated more for the \$250,000 appropriation than that derived from the work at the Louisiana Home. No treatment of leprosy introduced elsewhere has been more effective than that used at the Louisiana Home. Whenever new treatment has been suggested elsewhere, the Louisiana Home has tried it, but has found none better than that originally adopted in 1895-1896.

The determination of the presence of Lepra fever as a characteristic syndrome in leprosy, and Hopkins' work in this phase of the disease, is recognized as original.

More leprosy up to the present has been cured in Louisiana and at the Home than in any other country during a like period. The systematic cure of leprosy was announced by Dyer in 1899 and fully reported in 1902.

The experimentation with attenuated snake venom (antivenomous serum) was originated by Dyer in 1896, and reported at the Berlin Conference in 1897.

The establishment of the Leper Home and the study of the cases there fixed the endemicity of Leprosy in the United States.

No other field of leprosy in the United States has been as intensively studied as that of Louisiana and no other city, state, or locality has contributed to the history of leprosy, or to the public or professional interest in this disease as has the work done in Louisiana by Joseph Jones, Blanc, Dyer, Hopkins, Duval, Wellman, Gurd, Harris, Couret and Seemann.

The material from the Louisiana Home has afforded opportunity to others for research. Fox (H) published an extensive Wassermann survey of the Louisiana Home.

The various treatments at the Home have included: Chaulmoogra oil, strychnin and hot baths (Dyer method); saponified Chaulmoogra oil subcutaneously; Mercado formula (resorcin,

camphor and chaulmoogra); Varham's colloidal solution of Chaulmoogra (France); normal horse serum; Duval's serum and vaccin; erysipelas vaccins; chlorate of potash; ichthyol; arsenic; hoanganan; red mangrove bark; sodium fluoride; emetine; sodium salicylate; iodids; fat series (e. g. lanolin, olive oil, cod liver oil, etc.)

The Louisiana Leper Home has been model in its domestic administration and under the care of the Sisters of St. Vincent de Paul the whole atmosphere has been moral and wholesome.

The State of Louisiana need have no regrets in the way in which the Louisiana Leper Home has fulfilled its obligations and there is needed no apologist for it, even though Governor Parker may now appear to assume that role. The Home has made history and its usefulness will not end, even if a Federal administration should inherit so splendid a monument to the foresight, capability and loyal duty of the medical profession.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### ON THE PREVALENCE OF CARRIERS OF ENDAMŒBA DYSENTERIÆ. AMONG SOLDIERS RETURNED FROM OVERSEAS SERVICE.\*

By CHARLES ATWOOD KOFOID and OLIVE SWEZY,  
University of California.

Dysentery has long been known as one of the major horrors attendant upon war. Its effects are recorded not only in the roll of honor and the pension lists, but in reduced levels of health and resistance to disease of survivors and in widely spread foci of infection which follow in the wake of dispersing armies. This is especially true of the dysenteries and diarrheas of protozoan origin due to intestinal infections by *Endamœba dysentericæ*, by the flagellates *Giardia*, *Chilomastix* and *Trichomonas*, and to a less extent, by the ciliate *Balantidium*.

In contrast with the bacillary infections producing dysentery, the protozoan infections appear, in the light of our present knowledge, to be more persistent and to pass more readily into the carrier phase in which the host may apparently have normal health, though liable to relapses. In this carrier phase the infected person is discharging intermittently great numbers of encysted stages of the parasite and becomes a permanent menace to the health of his family and associates as a source of new initial infections in the family and community. Medical literature of the last century bears witness to the ravages of dysentery in our Civil War and thereafter and of the efflorescence of dysentery and liver abscess in the United States after the Spanish-American and Philippine Wars, and in Germany after the return of the troops from the Boxer expedition.

The recent World War with its Egyptian, Mesopotamian, Balkan and Turkish campaigns, and its Western Front with troops of intermingled nationalities, has afforded unprecedented facilities for

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\* Read at the New Orleans Meeting, American Society of Tropical Medicine, April 26, 1920.

the appearance of epidemics of dysentery and for the establishment of carriers of the infective agent. The extensive laboratory surveys and determinations of protozoan and bacillary infections, which have been published as a result of the war indicate that many of the cases in the epidemics were of bacillary origin, while the fecal examinations of dysenteric convalescents, as well as those of non-dysenterics has brought to light high percentages of carriers of the dysenteric ameba.

On the other hand, the number of carriers of the bacilli of dysentery appear to be relatively few among such patients. It seems probable from the statistical results that much dysentery of amebic origin passed undetected or was masked or preceded by that of bacillary origin.

For purpose of illustration it will suffice to note the summary of the results of the fecal examinations, mainly of convalescent dysenteric patients from the Western Front, made at the Liverpool School of Tropical Medicine by Matthews and Smith (1919). They report 23,024 examinations of 4,068 cases with the following results:

**Percentages of Infection by Protozoa in 4,068 Dysenteric Patients among British Soldiers at Liverpool.**

Protozoan	Number of Cases infected.	Percentage infected of total examined.	Probable percentage of infection based on expectation after six examinations.
<b>E. histolytica</b> .....	494	12.1	23
<b>E. coli</b> .....	1,208	29.7	50
<b>E. nana*</b> .....	279	16.6	....
<b>G. intestinalis</b> .....	669	16.4	26.3
<b>C. mesnii</b> .....	148	3.6	12 to 15
<b>T. intestinalis</b> .....	29	0.7	....

\* Based on last 1,674 cases examined.

Ravaut (1916) and other French observers noted the increased incidence of amebic infections among the French soldiers and citizens as the war progressed and traced some of the initial outbreaks to contacts with colonial troops of African origin or previous service.

The degree of infection among our own soldiers both overseas and home service is indicated by the results of examinations of returning soldiers in Debarkation Hospital No. 3, at New York



City, and of home service men of the Port of Embarkation who had not been overseas, reported by Kofoid, Kornhauser and Plate (1919). This investigation included 2,144 overseas and 559 home service men and revealed 276 and 22 infections respectively of *Endamæba dysentericæ* or 19.9 and 3.9% in the two groups. A later report on this work by Kofoid (1920) shows infections in 2300 overseas men and 576 home service, as indicated in the accompanying table.

This tabulation indicates 297 cases or 12.8% infection with *Endamæba dysentericæ* among the overseas men to 25 or 4.3% among the home service men, a three-fold increase. The home service group contained many men of foreign origin and a number of Florida negroes, a less typical assemblage of American citizens than the overseas troops. Furthermore, these results all rest, in the main, on single examinations. Had six consecutive examinations been made in each case it is highly probable that the percentages of infection detected would have been doubled, and perhaps trebled. The overseas men represented over six hundred different military units and included men who had not been out of Brest and Bordeaux, as well as seasoned veterans. Infections were by no means confined to men from the front. Many, but not all of the infected men who were interviewed reported a history of diarrhea or of a typical dysenteric attack, often recurrent. Very few of the men had dysenteric symptoms at the time of examination. They were in the carrier stage.

It is evident from investigations in European laboratories and from the data given above, that the War is returning into civil life great numbers of men who are carriers of the *Endamæba* of human amebiasis. If 12.8% of our approximately 3,000,000 overseas men became infected, there would be 384,000 such carriers or 768,000 if twice this percentage are infected.

An additional check on the degree of infection among soldiers of the home service group and in an overseas group with maximum exposure to infection has been afforded by a series of examinations made in conjunction with the Infirmary of the University of California and the California State Board of Health during the past year on returned soldiers who are now students of the University.

The results of these examinations are appended to the preceding table. There have been to date 154 soldiers examined for intestinal

Tabular summary of infections by intestinal parasites in 2300 overseas troops and 576 home service troops of the U. S. Army at Debarcation Hospital No. 3, New York City, N. Y.

CASES OF INFECTION.

	Total		Negative		Positive		Cestoda			Nematoda			Rhizopoda			Flagellata			Miscellaneous				
Overseas	2300	763	1537	0	10	0	0	160	136	26	473	675	297	1	1	3	3	4	97	131	7	784	194
Home Service	576	243	333	1	3	2	22	14	1	92	161	25	1	1	1	1	3	4	20	37	4	181	57

PERCENTAGES OF INFECTION.

Overseas	33.1	66.9	0.0	0.4	0.0	0.0	6.9	5.9	1.1	20.5	29.3	12.8	0.1	0.1	0.1	0.1	0.2	0.2	4.2	5.7	0.3	34.1	8.4
Home Service	42.2	57.8	0.2	0.5	0.3	3.8	2.4	0.2	15.9	27.8	4.3	0.2	0.2	0.2	0.5	0.2	0.7	3.5	6.4	0.7	31.4	9.8	

Tabular summary of infections in 91 overseas troops, 34 home service troops, and 29 troops of unknown status examined at University of California, Berkeley, Calif.

Overseas	91	6	85	0	0	0	1	4	0	44	64	61	0	0	0	1	0	0	4	6	0.0	65	16
Home Service	34	5	29	0	0	0	1	1	0	10	22	9	0	0	0	2	0	0	2	1	0	19	6
Unknown Status	29	6	23	0	0	1	1	0	0	8	14	12	0	0	0	0	0	0	1	0	0	14	1

PERCENTAGES OF INFECTION.

Overseas	6.6	93.4	0.0	0.0	0.0	1.1	4.4	0.0	48.4	70.3	67.0	0.0	0.0	0.0	1.1	0.0	0.0	4.4	6.6	0.0	71.4	17.5
Home Service	14.7	85.3	0.0	0.0	0.0	2.9	2.9	0.0	29.1	64.8	26.5	0.0	0.0	0.0	5.8	0.0	0.0	5.8	2.9	0.0	55.9	17.6
Unknown Status	20.7	79.3	0.0	0.0	3.4	3.4	0.0	0.0	27.6	48.3	41.4	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	48.3	3.4

Protozoa by us at Berkeley. Of these 91 are overseas men, 34 home service, and 29 as yet undetermined. The numbers of carriers of *Endamæba dysentericæ* in the three groups are 61.9, and 12, or 67, 26.5 and 41.4% respectively. The infection in the overseas men is more than twice as heavy as in home service men. It is noteworthy that the infections by some of the other intestinal protists and by whipworm are also increased in overseas men as compared with those in the home service ones. For example *Endamæba coli* is increased from 29.1% to 48.4%, *Giardia intestinalis* from 2.9 to 6.6%, *Blastocystis hominis* from 55.9 to 71.4% and *Trichuris trichiura* from 2.9 to 4.4%

The degrees of infection detected in these examinations are, as a whole, distinctly higher than those found by us at New York. The difference results from the following causes. (1) A larger number of examinations in most cases, (2) increased accuracy in examination as the result of experience, and (3) the probability that this group of overseas men had a maximum degree of exposure in the period of greatest spread of the contagion on the Western Front and (4) possibly the longer time for the development of infections before examination.

Whereas the men examined at New York received, in the main, only a single examination, we have been able to make a total of 589 examinations of the 154 men at Berkeley, an average of 3.8 examinations per man. Only 33 of them had but a single examination while 66 had six. This increase in the number of examinations per man from about 1 at New York to 3.8 at Berkeley, might be expected to at least double the percentage of infection by *Endamæba dysentericæ* detected in the examinations. We find, however, that the percentage rises from 12.8 to 67% instead of 25.6% so that other factors than the number of examinations must be operative to account for the increases in percentage. It seems probable that increased accuracy resulting from experience contributes only a small part of this.

These records of infection by *Endamæba dysentericæ* rest upon careful identification of the organism in the encysted stage in preparations stained in iron hæmatoxylin, as well as in the temporary iodine-eosin stain of Donaldson. The possibility of confusion with other organisms is largely eliminated by the concurrent determinations made of all other known protists in the stools.

The overseas men of this group belonged mainly to the 91st



Division which saw hard service in the Argonne drive and later on the Belgian front in the closing days of the campaign. Many of them testify to the widespread prevalence of intestinal troubles and dysentery during both field campaigns. No critical evidence is available to determine the relative amount of bacillary and amebic infections during the campaigns or at present.

This percentage detected in our overseas men (67%) is over 50% higher than the expected percentage in the men examined at Liverpool or New York. The Liverpool statistics were gathered several years prior to ours from men retired from the front at that time. Our men had the exposure to the cumulative effects of spreading contagion in the last year of the war.

Not a few of the home service men examined at Berkeley were in the Southern training camps in a territory where infection by *Endamæba dysentericæ* is to some extent endemic, though the probability of much increase in these infections as a consequence of exposure within army camps is relatively slight owing to examinations of foodhandlers, and effective measures of fly control, which prevailed in the army camps, but less effectively in their environs.

The men examined in New York were convalescent patients in transit from Europe to various camps in the United States for discharge, and were recently from the zones of exposure to infection. The men examined in Berkeley have had an additional six months to almost a year for the parasites to multiply or die out. Evidence for so-called spontaneous cure of such infections rests in the main on an inadequate number of stool examinations.

The sequelæ of such infections are varied. The dysenteric syndrome is only one of several manifestations. The clinical histories of cases of amebiasis may exhibit abscess of liver, lungs, or brain, inflammation of the appendix, enlarged spleen resistant to quinine, long bone and joint rheumatism, and obscure and rebellious types of skin infections. The carriers we have detected exhibit none of these consequences, though some of them are clinically in subnormal health at present. Some are apparently normally robust, but all are potential sources of infection since their feces intermittently contain cysts, the cause of contagion.

The data here presented are indicative of several conclusions in regard to so-called tropical amebic dysentery.

1. The number of carriers of amebiasis in the United States

has been greatly increased by the infections in soldiers returning from overseas.

2. A larger number of carriers than has hitherto been suspected exists in the normal population in this country.

3. The dysenteric syndrome is not an essential feature of the disease and the infection is by no means limited to the tropics.

4. The carrier phases are persistent and afford possible foci of contagion.

5. The percentage of carriers relapsing or developing serious sequelæ is as yet unknown.

It is obvious that the prevalence of carriers of amebiasis in this country demands increased vigilance on the part of the federal, state, and municipal health authorities. The fact that the organism can not multiply outside of the body and that the progress of the contagion under normal conditions of sanitation is slow, makes an epidemic of amebiasis quite improbable. Its spread by food handlers, by household contacts, and, in favoring circumstances of poor sanitation, by flies and water, will make its progress all the more insidious because it is not catastrophic and because an unknown but probably large number of infected persons exhibit no symptoms of disease, or no symptoms associated with dysentery.

Increased attention is called for on the part of the practitioner in all obscure intestinal cases to the possibility that *Endamæba dysentericæ* is the etiological factor or accessory to the disease.

It is also eminently desirable that the United States Public Health Service, the Red Cross, and other social service agencies co-operate to detect and free, as far as feasible, our returned soldiers from the incubus of this infection in a thorough and effective manner. We owe it to them and their families and to the community, and it is not impossible of accomplishment.

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## TRACHOMA EXISTS IN LOUISIANA AND JUSTIFIES INVESTIGATION.\*

By T. J. DIMITRY, M. D., New Orleans.

Before proceeding with my contribution I request the privilege of showing to you a few cases of trachoma. This clinical demonstration tends to lend emphasis to the subject, and my remarks can hardly be considered radical in that you are here presented with facts in proof of my assertions. Such a presentation carries greater importance than photographs and sketches.

These two children, attending school in this city are the victims of trachoma. I dare say you agree with me that they are pitiful sights. This child finds it difficult to navigate, as the lachrymation and photophobia are so great that it is necessary to keep his eyes closed. You can readily note the secretion on the eyelids. This child would bury his head in a pillow and remain there if permitted. It is impossible for him to make any progress in school and his outlook in life is very gloomy.

The condition in his brother is not quite so bad, though both are in an undoubtedly sad plight. These children have received treatment for the last three years at the hands of our very best ophthalmologists, and they have made little progress, hence it would seem that we are justified in accepting the prognosis of many who state that trachoma once developed is never cured. I wish it well understood that these children are suffering from the effect of advanced trachoma, for the lids are filled with scar tissue and we can note the pannus on the cornea. Many demand this advanced picture to enable them to make diagnosis. When the disease is acute, and when dealing with borderline cases, there is always great disagreement and insurgents offer obstruction to hygienic precautions.

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\* Read before the Orleans Parish Medical Society May 20, 1920. (Received for publication June 10, 1920.)

Both of these children were born in this city. Their parents and grandparents were born here—they are native Louisianians. The following question is entirely justifiable: Did their parents have the disease and did their great-grandparents bring it from the old world? Their parents and grandparents did not have it. I believe that these children acquired the disease in one of the institutions of our city, for they have been inmates of our charitable homes. Am I not justified in advising investigation?

The third is this young boy of 14. He and his parents were born in this city. This boy became infected with the disease while being treated for an interstitial keratitis. I believe that this infection occurred at the hand of my assistants or myself, or if I am wrong in that belief a very likely source of infection was through his intimacy with trachoma case number four. I have been able to discover that they occupied a single bed for a number of days while in the hospital and subsequently became infected, and still further, these children are in a *medical* ward in the hospital. All care to prevent propagation had been ignored.

This boy had a positive Wassermann and his mother and other members gave a like reaction. When I first saw him he did not have trachoma—a few weeks after the eye developed an interstitial keratitis and while responding nicely to treatment trachoma developed. His trachoma is now cured but it has left the ear marks, and the diagnosis is not to be questioned. You may also note the result of his interstitial keratitis in the other eye.

Case number four, a young boy of eight. He and his parents were born in Louisiana. He has been an inmate of one of our institutions and it appears that he developed the disease there. His family history is negative. His condition was equally as bad as in case number one. He is cured. He received ten days ago, the tarsal manipulation treatment that I advocate.

Cases five and six are cured cases of trachoma. They were both born in this city and became infected here. Case number eight is as case number two, he was born in this city.

I have presented a clinic showing that the disease exists among our native population, and will you not admit that, if this disease is what it is defined to be, then we are dealing with a very serious problem, and that it behooves us to ignore the obstructionist who wishes all evidence of its mutilating effects in order to make his diagnosis and who handicaps all hygienic progress.

All authorities accept practically the same definition: trachoma in an infectious disease of the conjunctiva and it tends to chronicity and hypertrophy of this mucous membrane and transforms portions, and at times all, of the conjunctiva into cicatricial tissue. There is a certain stage of the disease when we contend with an abundance of secretions, and through this secretion the infection is spread. The etiological factor in the production of the disease is unknown.

Trachoma is probably scattered throughout the world and is endemic in many countries. As to the United States it is East, it is West and it is North and South, and the centre is not free of the disease. There are thousands of cases in the mountains of Kentucky. Dr. John McMullen gives some very interesting figures on the subject. Dr. White says that 80% of the Indians have the disease. Others tell us that 65,000 cases are to be found in the Indian population. In Texas, New Mexico and Arkansas, trachoma is commonly noted. The ophthalmic clinics of the city of New York offer a display of the cases most instructive. In 1909, 1083 cases were detected trying to enter the port of New York. The Washington news of this day informs us that 600,000 immigrants are prepared with passports ready to enter our country. How many of these will have the disease, and how many will slip through?

Ninety per cent of the population of Egypt is suffering from the effects of trachoma. When Napoleon's army returned from this infected land seventy-per cent of his soldiers were suffering with the disease. They propagated the disease throughout Europe. Eight to fifteen percent of the labor brigade that was brought into Europe at the beginning of and during the recent war was infected with trachoma. Our American Army are to be complimented for preventing the ravages of this disease by the excellent watchfulness given to our soldiers. England and France had their fears and it was only by prompt attention that history did not repeat itself.

What are the conditions in Louisiana and what precautions are taken to prevent its spread? In answer to the first we know that the disease exists here among our native population. We believe that the condition is not as bad here as in other places, though we lack proof of this, for we lack records that would give us any

information on the subject. In the Sanitary Code of the State of Louisiana added February 18, 1915, we find:

“For purposes of investigation and statistical records, pellagra, trachoma, hookworm, malaria and whooping cough are hereby made reportable diseases in the State of Louisiana, and attending physicians must report to the La. State Board of Health and to the respective local health officials all cases of these diseases in the same manner as provided in Section 13 of the Sanitary Code.

(Cards or envelopes will be furnished all physicians so as to save expense of postage.)

In a communication to Dr. Dowling, President of the State Board of Health he furnishes the following data:

Five cases of trachoma have been reported to him during the year 1919-1920.

Homer—Claiborne Parish.....	1
Kaplan—Vermilion Parish.....	3
New Orleans.....	1
Shreveport.....	1

Since this communication I have been able to report to the health authorities as occurring in my hospital work and my private practice thirty-one cases—3 of these are totally blind.

Our school inspectors are investigating this disease, though I doubt if in the last few years any work at all has been done by any experienced eye man in the schools. I know that St. Bernard Parish is possibly the foremost parish in the State in investigating the health conditions. The work accomplished in that parish is ideal. Not alone is inspection provided for but also treatment. I fear that many labor under the impression that the disease is essentially in the foreigner. Such is not the case. Again, it is often stated that it is noted principally in institutions and where large population is gathered together under unhygienic surroundings, though it is found in these places the disease is a rural disease and the census reports are convincing on this subject. The greater numbers were found among the stock raisers and agriculturists.

Is trachoma a national problem? This has been answered by enacted laws and by the assistance given by the government to prevent its spread and to render assistance to the unfortunates. We have the Federal immigration act providing for the exclusion of persons with “dangerous contagious diseases” now applying in force in respect to this disease. In 1897, trachoma was declared



a contagious disease by the Secretary of the Treasury. There are seven trachoma hospitals in the United States, three in Kentucky, one each in Virginia, Tennessee, West Virginia and North Dakota. In 1913 a law enacted in 1882, authorizing the president to employ public funds for the suppression of actual or threatened epidemics, was made to apply to trachoma. In large cities special schools and classes have been established for the trachoma children. It is well to remember the great number of Indians infected with the disease, probably 80%.

Now I ask, is it not a problem in Louisiana? The chief requirements for the prevention of any disease is the compulsory reporting to the health authorities of all the cases. This is provided for in our sanitary code but it is not obeyed. I have been able to show you a number of cases which should convince you of its existence in our state and among our native population. This demonstrates a potential danger.

I wish it understood that I do not wish to alarm, but merely to warn. Do not neglect the reporting of the cases. It is essential to the success of any campaign. Why not systematically investigate the problem in our state with the view of discovering the true condition and the method of combating it?

#### DISCUSSION.

**D. V. C. Smith:** "I seldom see a case of trachoma and rarely in my private practice. Nearly all I have ever seen have been in patients of foreign parentage with hardly an average of one fresh case yearly. I do not believe that trachoma is curable. Trachoma inevitably produces scar tissue and if there is no scar tissue patient did not have trachoma. I do not believe that the disease is prevalent to any dangerous extent in Louisiana.

**Dr. J. B. Guthrie:** In Camp Beauregard, Louisiana, 1700 troops from different districts of Louisiana, Mississippi and Arkansas were encamped and during the nine months in which I was connected with the Camp as a member of the Disability Board, 26 cases of trachoma were discharged from service. The majority of these cases were from Arkansas and Mississippi, Louisiana having the least.

**Dr. Chas. A. Bahn:** Of the 750 cases seen by me in office practice since my return from military service, there have been seven cases of trachoma or trachoma observation, of which three were old and non-contagious, two recent and probably contagious and two suspects, later proven not to be trachoma.

In the Eye, Ear, Nose and Throat Hospital Clinic, one of the largest in the city, there have been six recent cases of trachoma this year and we have performed only three tarsal excisions which operation is done in most chronic inflammatory cases of the disease.

I do not believe there are 500 cases of trachoma in the state of



Louisiana, of which 10% may be contagious. I hardly feel that we are menaced by a ravishing scourge of the disease and need not work the hardships on the community that have been done in out-bursts of trachoma enthusiasm in other cities. The researches of Kuhnt have proven that any massage treatment of the conjunctivæ or tarsus does not cure without cicatrization, does not prevent re-infection and the infection of others for a prolonged period.

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## PARENTERAL INJECTIONS OF COW'S MILK.

By DR. A. DARIER.

(Translation from *La Clinique Ophtalmologique*, by T. J. DIMITRY, M. D.,  
New Orleans, La.)

This therapeusis was introduced by Müller and Thaner of Vienna, in 1916 (*Med. Klin.* 1916) in the treatment of the iritis and other ocular infections (see analysis of this work in detail in *La Clinique Ophtalmologique*, December, 1916).

After experiments made in inflammations, following blennorrhæa, they carried their experiments to ocular infections, and particularly iritis. They obtained rapid cure characterized by the rapid cessation of the pains and of the photophobia. (The same result was obtained by us long ago, by means of the para-specific serotherapy by mouth as well as parenterally).

In the "parenchymatous keratitis," they observed an immediate suppression of the photophobia and a decrease in the duration of the affection, which becomes notably more benign, as in iritis. The intra-venous injection provokes a more violent fever but it is more efficacious, the pain oft times disappears as it does after a narcotic.

Pfluck (*Woch. f. Th.*, No. 41, 1917) speaks still more highly of the results obtained in Vienna, in parenchymatous keratitis, iritis and opacities of the *vitreous*. This action was remarkable of above all others, in a case of blennorrhagic ophthalmia with perforation of the cornea. (This is again a fact similar to the one observed by the serotherapy.)

Dimmer obtained surprising results in two cases of iritis and rheumatic kerato-iritis. In the parenchymatous keratitis, the improvement was only temporary; according to this author, para-specific serotherapy would act like the milk.

Friedlander is reported to have cured 40 cases of old trachomas.

Domec mentions two cases of ulcers with *hypopyon* of a trau-

matic origin taken in their incipency and cured within two or three days; the ulceration in both cases was altogether superficial and the same therapeutical result would have been obtained by the usual means. It was observed that fifteen other cases were cured with the same rapidity. In one case, however, the treatment is reported as having remained without result; finally in one case of serpiginous ulcer (the other eye having been lost due to the same affection) cure was effected in four days with satisfactory vision.

In a case of traumatic irido-cyclitis with pupillary exudate and hypopyon, one injection of milk brought the disappearance of the pupillary exudate and of the hypopyon in twenty-four hours, and the cure after four injections with  $V=0.8$ . This case is extremely interesting, likewise the following one, irido-cyclitis with hypopyon, where the first injection of milk caused the disappearance of both, the hypopyon and pupillary exudate.

A third case of the same kind is reported to have improved under the same conditions.

In four cases of irido-cyclitis of endogenous origin, the results of milk injection reported were equally favorable. Domec adds that, in similar cases, Roux' serum would have given him similar results, although less lasting.

In post-operative infections, Domec obtained eight very fine results out of ten cases treated.

In abscess of lachrymal sacs, particularly when they opened spontaneously, the pus dried up in the space of forty-eight hours, and ten days after the wound was completely healed. Five suppurative *chalazions* healed in the same manner.

Kerato-conjunctivitis, eczematous or phlyctenular—The Milk treatment,—Domec obtained marvelous results in such cases, less than forty-eight hours after the first milk injection he sees the eyes open and the pustules melt almost immediately; strumous children are cured in less than eight days. Two injections of from one to two cc., at intervals of from two to three days, are sufficient for children under ten years old. The local and general treatment must not, however, be neglected.

In two cases of parenchymatous keratitis, Domec is reported to have had good results, but the only observation he cites is not conclusive.

I have, myself, practiced numerous injections of boiled milk and

my general impression is rather favorable to this new therapeutics which offers about the same advantages as para-specific serotherapy. Later we will establish a parallel between these two medications.

From my view-point, the number of cases treated has not been great enough to permit of firm conclusions as the subject is new, and with a therapeutical agent as variable in its qualities, as is milk, purchased of the first comer, without one knowing anything of the cow that supplied it. I wish to give here only my actual impression on this subject.

I treated five cases of parenchymatous keratitis of from 12 to 23 years, of which Bordet-Wassermann test was positive plus 4; my impression is that the milk *in one case* produced a *favorable* result while the intra-venous injections of Cn Hg seemed not to have any more marked effect as it had at the beginning. However, it became necessary to return to the specific treatment, to bring about the cure, milk appeared to have only a doubtful action.

Unfortunately, I have not been called upon recently to treat parenchymatous keratitis of tuberculous origin. I did not obtain, with the milk, the rapid cessation of photophobia and blepharospasm which I had observed after the injections of antidiphtheritic serum or its administration by the mouth.

One must not lose sight of the fact that this action of the serum is above all palliative. We will observe, however, that Walther noted a great improvement of the tubercular parenchymatous keratitis after a few injections of the antidiphtheritic serum. I prefer, in such cases, the anti-tubercular serum followed with a tuberculine treatment (see the *Clinic Ophth.*, 1915, p. 613). It is probable that milk injections in such cases will have a more marked action than in the heredo-specific form.

In infectious ulcers of the cornea, the first few days, cure will most probably be effected by means of the usual "antiseptics," argyrol, sulphate of zinc, etc., combined to the use of dionin and optochin; if there is hypopyon and pain, should be prescribed with 10 to 20 cc. of antidiphtheritic serum in the twenty-four hours, during four or five consecutive days. By this means, I generally cure all infectious ulcers, in the first degree.

In more serious cases, good results can be derived from milk injections, but I must admit that where I am concerned I find this last agent in no way more effective than the injections of serum.

I recommend them, however, in all cases where serum or anaphylactic accidents are feared. In serious cases, I have never been able to accomplish cure, with milk injections alone, they did not cause the hypopyon to disappear and did not stay the progress of the ulcers. Cure had to be perfected by means of cauterization with the galvano cautery, and once I had to have recourse to Sæmisch's incision. Almost all favorable observations published cover benign cases, or at least those ulcers in the first degree in which the corneal erosion, sometimes very extensive, does not progress into the stroma of the cornea. These cases I repeat are the easiest to cure, by any means resorted to.

The number of cases of infectious ulcers cured by para-specific serotherapy are very numerous, if we are to believe the authors cited, as far back as 1911.

In post-operative and traumatic infections of the cornea, milk injections will serve the same purposes in cases where serotherapy, so simple and so effective, by way of the mouth, will not have given entire satisfaction.

The same will apply in cases of iritis or iridocyclitis produced by endogenous infections: syphilis, tuberculosis, gonorrhœa, etc. In the last two forms, and particularly in ocular tuberculosis, I have had the impression that milk injections have a favorable action, but inferior, however, to that of antidiphtheritic serum.

In a case of intense iritis, aspirin having failed to give results, I had the patient take a serum (10 grm. of serum each 24 hours); in four days all pain had ceased, and the pupil dilated well, without atropin. I then had the idea of resorting to another milk injection of 4 cc. and discontinue the use of the serum. There occurred a new and violent recurrence of iritis. The serum administered, soon restored and improved conditions with prompt cure. It is possible that further injections of milk would have been necessary, but the patient objected, the first one having provoked violent fever.

In intra-ocular diseases of the eye: chroido-retinitis, optic-neuritis, etc., results were very variable.

In one case of macular choroiditis, most probably tuberculous, in a gouty youth with tuberculous antecedents, after a complete failure of sub-conjunctival injections of cyanide of Hg. and little effects from colchicine, a great improvement was manifested *after* a series of 10 injections of milk, of 5 cc. (post vel propter hoc?)



In another case, without any characterized antecedents, the perimacular choroiditis did not cease to make progress in spite of twelve injections of milk etc.; the patient can hardly see to go about.

In affections of the *conjunctiva*, milk injections are said to have given at times brilliant results, and at others results were almost nil; thereby, opinions are somewhat divided in that respect. Here again, the effects correspond to those obtained by paraspecific serotherapy. In fact, in blennorrhagic conjunctivitis with corneal complications, results obtained from injections of antidiphtheritic serum have often been most favorable; ulcers of the cornea heal easily after a rapid decrease of the conjunctival secretion. (See *la Cl. Oph.*, 1899, No. 1; 1903, No. 5, etc.) Lagrange and Teuliers observed two cases of rapid improvement in purulent ophthalmia with ulceration of the cornea. (See *Clin. Oph.*, 1910, p. 577.) Galenga relates several favorable cases (*la Clin. Oph.*, 1910, p. 598); Frogier, also, publishes a very interesting observation. (*la Clin. Oph.*, 1909, p. 607).

For my part, serotherapy is a precious means in purulent conjunctivitis, the secretions are rapidly reduced, photophobia disappears promptly and at the same time that the ulcerations of the cornea heal.

These are the same results attributed to milk injections by Friedlander, Rosenstein, etc., in granular conjunctivitis. Orlando Pes obtained from sub-conjunctival injections of serums, a rapid resorption of the inflammatory products. Piccaluga (*la Clin. Oph.*, 1910) combined sub-junctival injections of anti-diphtheritic serum, with the same injections, hypodermically, in the treatment of granular conjunctivitis with *pannus*. The effects were surprising.

For my part, I treated only two old cases of trachoma, with milk injections. The patients got relief, but I cannot say that they were cured.

In the ophthalmic zone, paraspecific serotherapy administered the first days often gives remarkable results; cessation of pains, prompt healing of the pustules, and disappearance of the tumefaction of the tissues. In one case of that kind only, did I use milk injections; the results were rather favorable after fever. This is all I can say until I have more ample information.

*Skin Affections:* Schrameck related a case of vegetating pemphigus of a serious character, in which he was successful, with



parenteral injections of serum, and with the assistance of tuberculin obtained complete disappearance of the principal phenomena. There was a recurrence of the trouble after several months. I, myself, observed a case of impetiginous eczema which had covered a baby's entire head, into a ball of scabs. After a few injections of the antidiphtheritic serum, all the scabs dropped off and in less than a month the face of the child had resumed its normal aspect.

Domec observed that in eczema of the eyelids and of other parts of the body, injections of milk bring about a drying up of the surfaces, then the scabs drop off and the skin resumes its normal aspect.

I saw ulcers of a lupic tuberculous aspect, 20 c. high by about 15 wide, on the leg. The patient was thirty-five years old and had gone through the most varied treatments at the St. Louis Hospital, including radium and X-rays. Believing it to be of a tuberculous origin, I tried frictions of guaiacol, without favorable results.

I then gave the patient the milk injections. After the fifth, in the space of three weeks there was a notable improvement and at the end of a dozen injections the entire surface was healed, the edema of the leg had entirely disappeared and the patient walked well, without pain and without fatigue.

I left the patient, for a six weeks vacation; on my return I was surprised to find him completely cured. Today, after nine months, the ulcer is still healed, but on the lower portion on a line with the leather on the back of the shoe heel, can be seen three or four prominences, scabby tuberculoids. The patient still received one or two injections of milk monthly, of 5 cc.

In articular rheumatism, milk injections had given good results to different authors. Müller and Weill noted that fact particularly in cases of blennorrhagic arthritis.

I tried injections of milk on patients suffering with albuminuric retinitis, but I noted no improvement, neither in the sight nor in the general condition. It may be that I used too small doses, 2 to 5 cc.

Clinical observations call my attention to peculiar effects of milk injections. A young woman, twenty-two years old, 3½ months pregnant, suffering with parenchymatous keratitis, with W +, not having been able to give her more than three intra-venous injections of enesol of 5 cc., the patient experienced something like uterine colic and she had me observe that her breast had become

hard and almost painful. I ceased these injections to take up intra-muscular enesol. At all events, the milk injections had not brought about reduction of the photophobia; it is even at that time that the second eye became involved. After five months of mercury treatment, the corneas are completely clear, the patient goes about by herself and sees to read with + 4 (atropin); milk may have had a share in this cure.

Another patient with serious infectious ulcers of the cornea, who did not derive any benefit from the milk injections (rather painful), appeared quite satisfied with the treatment because she attributed to it her being cured of *leuchorrhœa* which had troubled her for quite some time. I very naturally thought that these milk injections could have a special action on the genital organs of the woman, and in cases where the intra-venous injections of enesol increased menstruation and made it more frequent, I noted that hypodermic injections of milk counteracted this effect. I could then continue the injections four weeks without stopping, whereas previously I had to suspend them every fifteen days.

Another woman called my attention to the fact, that since the injections of milk she did not have the abundant flooding caused by a uterine fibroma. It is now three months since she has been compelled to remain in bed at period of menstruation, as she had been compelled to do for some years past.

Gynecologists might derive benefit from these observations, due to chance.

*Grippal Infections:* Milk, having a leucogenic and antitoxic action, very similar to that of antidiphtheritic serum, could not fail to be experimented with, in a number of diseases, both infectious and epidemic. In Germany, it was vaunted against rheumatism, against the most varied manifestations of gonococic infection. In France it was employed to fight grippal infections, and the most severe. If we must believe Dr. Gallois, head physician at the hospital of contagious diseases in Dijon, the results obtained surpassed by far all those obtained by all other treatment, including colloidal metal. Up to October 15, he had treated over 600 cases of grippé with a death rate of 18%, when Dr. Domec proposed to make experiments with lactated injections. He noted in the first cases, that in the few hours that followed an injection of 5 cc. of milk, a reaction was produced and the following day both the temperature and the pulse had lowered, dyspnea was at-

tenuated, cyanosis of the lips disappeared, and a feeling of comfort experienced by the patients. Lactated medication was then systematically followed in all cases where condition was critical, results were more rapid and more satisfactory. The younger subjects were those that reacted the sooner; this reaction is necessary and is almost always followed by a notable decrease of the fever symptoms. In older patients, particularly those with arterio-sclerosis, the action is less pronounced. One is compelled to recognize the action, manifestly antitoxic of milk, ridding the patients of their toxemia and curing rapidly, their local lesions.

Since three months that he is treating serious cases of grippe with milk, has Dr. Gallois observed in more than three hundred cases after effects or secondary complications, such as microbe infection of the lungs, bronchorrea, dilatation of the bronchial tubes, chronic broncho pneumonia, so frequent and so severe, following the actual epidemic of grippe. It must be observed that tardy application in secondary thoracic complications, the lactated treatment is not effective, a formal contra indication is tuberculosis. To obtain a rapid and favorable result, the treatment must be applied as near the incipiency of the disease as possible.

Observations made had bearing on over 300 cases, over one-third of which had broncho pneumonia or bronchitis complicated with pulmonary congestion; almost all of those who on their arrival did not present signs of asphyxia, were rapidly cured; once more, we were not accustomed to obtain such results.

I said in 1912, if there is infection of any kind, and the patient is given serum from a sound animal, he will thus receive a certain quantity of elements of defense, but if he is given the same dose of serum from an animal actively immuned, the elements of defense will be infinitely more numerous and more powerful. In 1901, Talamon was already bringing to light the successful effects of antidiphtheritic serotherapy, in pulmonary infections, all of which reduced the mortality by two-thirds on a series of 105 pneumonia cases; twenty-four hours after, the temperature had already decreased.

Since then, these experiments have been confirmed by many observers, but there is always fear of serious accidents. However, when the practitioner will be penetrated with the idea that a simple potion of the serum is the most powerful biological and anti-infectious tonic, he will not hesitate in giving his patients the benefit

of the treatment at the same time very agreeable and free of danger.

Paton, who for quite some time has been using serotherapy by the mouth, says he has never lost a single case of broncho-pneumonia, not even after the measles.

Personally, I have administered the serum by the mouth in many cases of gripe or broncho-pneumonia, with the most encouraging results. This treatment could be easily combined with milk injections. Reactions, produced by the injections of milk, are numerous and varied. The injection itself is not particularly painful, particularly so if the needle is not blunt. It is only a while after, the patient experiences a sensation of bruise more or less violent. In very stout persons, with the skin drawn tight, there is a local swelling and hardening, both apparent and painful.

The fever reaction is variable, according to the individual, but it is always appreciable by the thermometer after the fourth or sixth hour, it varies from 38 deg. to 41 deg. There is oftentimes headache and nausea, even hallucinations and delirium. But all these symptoms disappear as soon as the patient will have slept the second part of the night.

The hyperthermia, according to Domec, is often in keeping with the general conditions of the subject, scrofulous, debilitated, etc., etc. The following day there still remains a feeling of bruise on a line with the injection, and certain movements of the leg are still difficult and painful.

Personally, I have never observed serious accidents, but Domec noted cases of varied tolerance; one patient, after the sixth injection, suffered with insomnia and grew very thin, which necessitated the suspension of the treatment. In another case, the seventh injection, there occurred an immediate congestion of the face, the lips became cyanosed, nausea, pulse hardly perceptible, numbness in the upper limbs. Normal condition was restored after fifteen minutes. A strong feeling of fatigue persisted during 48 hours.

The first hypodermic is usually more painful than the following ones, therefore it is best to inject only 3 cc. the first time, and if the reaction is vivid, 4 cc. the second time, and finally 5 cc. the third time. In Germany, the doses most highly recommended go as high 10 cc. The first ones are given at intervals of three or four days; after the fourth, only one a week is given.

The intra-venous injections have been too little experimented



with to recommend them, as the accidents mentioned by Domec may have been caused by the penetrating of the milk into a vein.

*Sub-conjunctival* injections of milk have given very good results, according to Gaupillat.

Respective advantages and inconveniences of milk injections and paraspecific serotherapy:—

Milk taken by the mouth has practically no therapeutic action, whereas Roux serum has a very manifest action. By enema, the effects are much more marked.

Hypodermically, milk often provokes pains locally, that are likely to last two or three days, and condemn the patient to immobility; febrile reaction is often high, though syncopal accidents rare.

Serum offers none of these accidents, with a therapeutic action almost identical; but serum accidents occur at the end of the seventh day, eruptions and swelling of the legs.

In intra-venous injections of milk, especially if it is not well filtered, a reaction is provoked, sometimes very vivid, going as far as nausea, syncope, etc.

Roux serum offers none of the above inconveniences, is well stood intra-venously without any reaction, unless there be anaphylactic accidents, which is exceedingly rare. The serum, thus injected, manifests its anaphylactic action less than an hour after, whereas hypodermically the anaphylactia is manifested only after the third hour, and only five or six hours after when the serum has been taken by the mouth.

With milk, the decrease in the pains is produced only the following day, after the reaction has taken place.

It is apparent that the injections of milk and the injections of serum, more yet than the injections of colloidal metals, have a therapeutical action, the most manifest and the most precious. They present respective qualities that may offer various indications. Thus, the possibility of being enabled to administer the serum by the mouth constitutes in its favor a marked advantage, this mode of giving it being the easiest, without any contra indications.

The treatment can therefore be thus started, to be completed later, if its action is not sufficient, with injections of milk. In serious cases, the two methods can be alternately applied, according to the principles established in the course of this work. I would thus proceed in the following case:

Mrs. A. was operated for the cataract under favorable conditions on March 1st. The first days, all goes well, but the patient suffering

very much with rheumatism for quite some time, complains on the fourth day of pains in the abdomen, the following day, violent pre-orbital neuralgia, the eye is very red with a **chemosis**, especially in the lower portion, no sign of infection in the wound which is completely healed, but the aqueous is cloudy, flaky, and the patient who previously could see the fingers very distinctly barely sees the flame of a candle. The patient is taking aspirin since the day before, I prescribe a potion of antidiphtheritic serum, 10 cc. daily. The following day, the condition is still worse, in addition to the serum, subcutaneous injection of 5 cc. of milk; two days later, other injection of 5 cc.; likewise, two other days later. That day, I note a marked improvement, the cornea, which still remains very transparent, permits one to see that the abundant **exudate** of the anterior chamber begins to absorb itself, and the pupillary orifice is seen for the first time, the chemosis has notably decreased, the patient sees a little the movement of the hand, the serum potion is continued. As a precautionary measure, a 2 cc. injection of turpentine is given in the left thigh. After seven days, after three injections of milk and six potions of serum, all trouble of the aqueous humor has disappeared, the iris has recovered and almost of normal tint; but the pupil is obstructed by a whitish exudate, very good light perception, the turpentine has produced no abscess.

Mode of action of parenteral injections of milk:—

We have known for the last twelve years, that antidiphtheritic serum taken by the mouth has a marked therapeutic action. Such is not the case with milk which, taken by the mouth, is an excellent food, and aside from its action of being an antidote to poison does not appear to possess any particular therapeutic properties.

Nolf and R. Müller have studied the action of several albuminoids in parenteral injections, on localized inflammatory processes and have mentioned good results in blennorrhagic complications, *bubos*, staphylogenic processes and others. Leaning on clinical observations, believes he can explain the effects produced, by an increase of the hyperemia, and by the transudation in the seat of inflammation; other processes, and above all hyperthermia and leucocytosis act an important part. He believes that vaccins, aside from their specific actions, exercise a marked action by products that are not specific of the decomposition of albuminoids which provoke hyperthermia.

But it is not only albumen that acts in milk, there is also the lactose fats, salts, without counting the ferments that may be considered as annihilated by ebullition twice repeated. There are also microbes, living or dead.

Since Metchnikoff's remarkable discoveries, it is universally admitted that the essential element of defense of the organism, is the white corpuscle, whether this acts by digesting the microbe or neutralizes by its secretions the microbe toxins or others.

The important question in all infections is to increase the organ of defense, bacteriotropic antiseptics not having as yet demonstrated their efficiency.

All means that increase the number and activity of the leucocytes constitute a previous therapeutic force. The higher the leucocytosis, the better is the defense of the organism.

The leucogenic medicines are listed by Audoin in the following order, according to activity:

1. Physiological serum between 7 and 12% (weak).
2. Colloidal metal (weak).
3. Antidiphtheritic serum (medium strength); it is more powerful than the colloidal metals, whereas antistreptococci serum is little or not leucogenic, that is what explains the weak action of these serums.
4. The nucleinate of soda would be the very best leucogenic, it provokes a strong reaction four hours after the injection—hypodermical—(sooner than intravenous injection) there is tachycardial chill and fever at 40 deg. and over. Unfortunately, the nucleinates are unstable.
5. Finally, the most powerful leucogenic would be turpentine in hypodermics; there is abscess formation (said of *fixation*) with abundant suppuration.

Audoin does not make mention of albumen or milk injections, but later (both) can be placed alongside the serum as leucogenics of medium power.

Is this the only way of explaining the action of the Milk? Most certainly not! According to Konteschweller, it is thermic reaction which would be the principal cause of the therapeutic action of parenteral injections of peptones and of milk; without thermic reaction there is no medicinal action, says he, and on this he bases a theory which he names pyreto therapy. This might prove true for the peptones, nucleinate or milk but not for the injections of serum and much less when these serums are given by the mouth and are accompanied by a prompt and marked therapeutic action as in the case of iritis cited above. The question is therefore complex, one must not be exclusive but seek the special indications of each agent so as to be able to alternate or cumulate their respective action. Milk is an agent, too complex and too variable, according to the source it comes from. The cow that supplied it may be or may have been tuberculous; in the second

and perhaps in the first alternative her milk may have a certain action on ocular affections tributary to tuberculosis.

To study well the therapeutic action of milk, it would be necessary to know the action of each of its elements; albumoses, salts, fats, lactose and ferments. Ferments were studied up by Blondel, then by Barialari, who gave injections of filtered sour milk (the residue of clabber). They conclude that milk serum from a normal cow is *hypotensor* but only in *hypertendous* persons. The other components of milk remain to be studied.

In the meanwhile, it will be necessary that all observers use milk prepared in the same manner.

The cow's teats would be aseptized as well as the hands of the one that would milk her; the milk would be received in a sterilized receptacle, immediately stopped up with the batting, then immediately brought to the boiling point during fifteen minutes, and after cooling boiled a second time, and then filtered with Chamberland's bougie, and then put up in a vial containing 5 to 10 cc. and dated.

A more simple method of sterilization was tried at Liverpool, by electricity on a large scale; according to Priestley, milk is thus deprived of all infectious organism, notably tubercular bacilli. Unfortunately, the author gives no detail as to the electric method employed.

Small vials could also be prepared, of sour milk, sterilized by electricity and not by heat, thus preserving the action of ferment. Cow's milk tuberculinized could be tried in ocular tuberculosis.

Condensed milk diluted to a 10th, could be put to the test.

*Conclusions:* Injections of milk are one of the most energetic stimulants of the general defenses of the organism. They act by activating the leucopoiesis and the phagocytosis, and also by provoking a temporary febrile condition.

Combined with serotherapy by way of the mouth, they constitute one of the surest means of fighting the most varied infections, and particularly so, infectious ulcers of the cornea, iritis, traumatic or post-operative infections.

In such cases, an average of 10 cc. of serum will be given each twenty-four hours, and every second day a milk injection of 5 cc., of course without neglecting the local treatment.

In the treatment of parenchymatous keratitis, and in granular



conjunctivitis, the effects obtained are very encouraging, but opinions are still divided on this subject.

In grippal infections, broncho-pneumonia, etc., in gonococccic complications, rheumatism, etc., the combination of serum and milk are more useful.

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## THE AMERICAN SOCIETY OF TROPICAL MEDICINE.\*

By HENRY J. NICHOLS, Major, Medical Corps, U. S. Army.

*To the Members of The American Society of Tropical Medicine:*

To begin with, I wish to thank the members for my election to the office of President of the Society. Insofar as this position is a personal reward for work, it is appreciated, and will be looked back upon with satisfaction. Insofar as it carries responsibility, I am glad to do my share in attempting to direct the affairs of the Society along useful lines. The responsibility apparently is considerable. In fact, a year ago I was told that the prognosis was bad. I began to feel that my only function might be to conduct the post-mortem, but it is evident that the patient is making a good recovery from the depressing influence of war and pestilence, and, like other convalescents, is undergoing a rebound to a better state of health than ever. Under these conditions it seems indicated that the presidential address at this sixteenth meeting should be devoted to the affairs of the Society rather than to any special professional subject.

It may well be asked why a Society which has had among its recent presidents such leaders as Gorgas, Thayer, White, Stitt, Strong, Craig, Rosenau, Ashford and Bass should ever be thought to be in a precarious condition. The answer is two-fold: First, the nature of our work; second, the prevailing state of national morale. American specialists in tropical medicine are comparatively few in number and are widely scattered, and it is difficult for any considerable number of them to meet at the same place at the same time. This fact makes some of our meetings very small as compared with those of the more cosmopolitan and fundamental specialties. We have about 108 active members, and our attendance is usually about ten to twenty. In comparison with the crowds so familiar in some medical meetings and so dear to Americans,

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\* President's Address, delivered at the 16th Meeting of the American Society of Tropical Medicine, held at New Orleans, April 26, 1920.

this handful might seem a poor showing, but it is really only normal. Small meetings are a handicap which we should accept, and it is peculiarly true of the worker in Tropical Medicine that he must be prepared to stand on his own feet scientifically and morally. Soon after our last annual meeting I sent a circular letter to all members asking for support in making a fresh start for the Society. A number of gratifying replies were received and some of these were illuminating as showing the peculiar character of our work. It appears that many members are unable to attend meetings or contribute to the program, but are sufficiently interested to keep up their dues. Many physicians are directly concerned with tropical medicine only a few years and some have chiefly an academic interest, but still for various reasons desire to be members. These members I believe should be held, and if anything in the circular letter gave any other impression I now wish to correct it. Anyone who has other qualifications and is willing to keep up his support should be welcome.

Our relatively small meetings make it especially necessary to have some binding tie in the form of publications. The single annual volumes of transactions which for several years were edited with such devotion by the Secretary, Dr. Swan, served a very useful end in keeping members in touch with each other. Then a monthly was started, but unfortunately for personal reasons could not be continued. Recently the *New Orleans Medical and Surgical Journal*, through the public spirit of its editors, Dr. Dyer and Dr. Chassaingnac, has carried us, and we are grateful for this assistance.

In looking to the future the Council has made efforts to find a more distinctive form of publication. The most feasible plan at present seems to be to publish our transactions as before in a single annual volume. Our income from dues warrants such an undertaking, and it will begin with this year. Eventually we may look forward to a special Journal, possibly under the wing of the *Journal of the American Medical Association*.

The second circumstance which caused our slump was referred to as the low state of national morale. After superhuman efforts of the War, there has undoubtedly been a general let down of interest and effort which is felt in our Society. Concentration and sustained effort have naturally been succeeded by a certain amount of indifference, but they are not lost qualities and will function again by degrees. The tremendous resources of our country in

natural forces and human energy will find expression and it is our duty as well as desire to play our small part as a Society in the Nation's life as best we may. The best way to be good social creatures is to organize and work in common on a common task. The tasks in tropical medicine for Americans are many, and our traditions already established in a short time are great. In the face of our national future, the Society, as the only national organization of its kind, is called on to put its affairs in order and go forward.

We now have 108 active members, 19 corresponding members, and 39 honorary members. We may look forward as a result of past experience, (1) to a small number of active younger members to carry on the meetings and publications. These members should be recruited from Government services such as the Army and Navy, the Public Health Service, and the Government services of our foreign tropical possessions; from physicians to tropical industrial companies; from practitioners in the South and in the Tropics; from medical schools and institutes in the Tropics and from schools of tropical medicine in this country. (2) To a larger number of older active members who will support the Society by membership, counsel and occasional attendance. These members will come from the same sources as the first group, or be graduates therefrom. (3) To corresponding members who will occasionally contribute to the meetings and give us points of contact with other countries; and (4) honorary members who will be a source of pride and stimulus. We also have our valued membership in the Congress of American Physicians and Surgeons, largely through the interest of ex-President Thayer. This membership should also stimulate us to live up to its standard.

In order to increase its membership and attendance, it has been proposed at different times to make the Society over into one of Preventive Medicine. But this field is already occupied by one or more Societies, while in tropical medicine we stand alone and have our own sphere.

It has also been proposed to enlarge our membership by taking in active members from Central and South American countries. To take such members as are qualified as Corresponding Members would certainly be desirable, but our Constitution clearly limits our active membership to American physicians. This is the American

Society of Tropical Medicine in the sense of the word as used by Secretary of State Hay.

Our future policy in regard to relations with workers in tropical medicine of other countries will naturally reflect national policies. It is not for us to decide these policies in advance. Individually we may and should have our own views, but our position as a Society should be in harmony with the national spirit and with the attitude of the majority of societies in the Association of American Physicians. At present, since our position as a nation is not yet closely differentiated, we should do what is nearest to hand—namely, to begin with our efforts, like our charity, at home.

The past two years have seen what is apparently an epoch in American Medicine—the discovery of the long sought cause of yellow fever by Noguchi. This discovery was made possible by the organization of the American Rockefeller Health Board and Institute. The findings at Guayaquil, which were reported at the last meeting, were confirmed at Yucatan this Spring, and Dr. Noguchi is at present in Peru investigating another outbreak. While adding more laurels to his eager and resistless spirit, this investigator has enlarged knowledge and given us more control over nature. In connection with the same plan of work, General Gorgas is heading a party which is already en route to Africa to attempt to settle the question of the existence of yellow fever in Africa.

It remains to thank our hosts for the arrangements for this meeting. The last meeting in New Orleans, under Dr. Thayer in 1911, was one of the most successful of our history. The present one, now seventeen years since the Society started, is held here again and naturally so as this is the natural headquarters of the Society. The Society looks to New Orleans and Tulane University to lead in Tropical Medicine. The Secretary-Treasurer, Dr. Simon, is responsible for the program arrangements and all the details of reorganization of the Society and deserves our especial thanks.

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**REPORT ON LEPROSARIUM, ISLAND OF CABRAS,  
PUERTO RICO.\***

By JOSÉ A. DIAZ, Chairman.

Translated for the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL  
by LODILLA AMBROSE, Ph. M., New Orleans.

[212] The committee now reporting complied with action taken by the Commission, and went on the afternoon of February 1 to the Lepers' Colony located on the Island of Cabras with the purpose of investigating from the sanitary, medical and social point of view the location and conditions of the life of these unfortunate beings. The committee found 41 lepers—15 women and 26 men—with two servants, a man and a woman, and under the direction of a practitioner in permanent residence. These individuals occupy two cement buildings, one for men and one for women, situated at the two extremes of the island, and also various huts of wood for the cases which are kept in bed by physical conditions. There is a small building which is used as infirmary and kitchen, and there are also various latrines on the edges of the little island and these drain into the sea; there is a cottage occupied as a dwelling by the practitioner, and a place for collecting rain water and this is the only source of this precious liquid for the island.

The huts occupied by the lepers are small with sufficient space for a bed, a table and a chair, disagreeable in aspect by reason of the filth and neglect of the linen, and there those unhappy people agonize in the process of dying more than living, without the sanitary and medical attention which they deserve, and at the mercy of two servants, kind but ignorant of all that relates to hygiene and medicines.

The buildings of rubble-work which the lepers occupy as dormitories are in very bad condition, unclean and unhealthful.

The infirmary and kitchen are in the worst of conditions; the latrines, old huddled huts, urgently need repairs; the quantity of water which the place for rain water can hold is insufficient for meeting the necessities of the colony, and it would be a real agony, if—as unfortunately often happens in Puerto Rico—it stopped

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\* Informe del comité nombrado por la Comisión de estudio e investigación de enfermedades transmisibles, con el fin de investigar sobre el terreno y del modo más exacto, las condiciones en que se desarrolla la vida de los leprosos bajo el punto de vista sanitario, médico y social. (Dictamen leído ante la reunión científica de la Asociación Médica del Distrito Notre, Marzo de 1918.) Bol. Asoc. Méd. de Puerto Rico, San Juan, 1918, xiv, 212-215. Copy used lent by Medical Society of City and County of Denver, Colorado. Pages of the original are given in square brackets.

raining for a time, because the lack of this liquid would make itself felt immediately, and it would be necessary to carry it from this city, which would be difficult of accomplishment owing to grave material and economic hindrances in transportation to that island.

[213] The poor and dismal aspect of vegetation demonstrates the sterility of that sandy, rocky soil; it is evidently impossible to cultivate useful vegetables, or to install gardens for brightening the utter isolation of those unhappy people.

The impression received by this committee is one of painful commiseration for those beings, condemned to live in exile, apart from the world, separated from their families and friends, lost to all hope of returning to home and its affections, damned to be forgotten by all, worse treated than the most hardened criminals yet innocent, with no other perspective before their eyes than the tombs destined to receive their mortal remains.

This situation of the Lepers' Colony in the full light of the twentieth century compels us to turn our faces toward the primitive epochs, and by a phenomenon of atavism there are reproduced in Puerto Rico the events which took place yonder in Palestine before the Christian era, and in Europe from the sixth to the fifteenth century, when leprosy was recognized as the most dangerous disease known in history. To be leprosy and to be driven off by the whole world, were the same thing. The places set apart for lepers were avoided like mouths of hell. The lepers could not cross the dividing line without the risk of being killed instantly. If a stranger, in good health and ignorant of the reclusion of these beings, entered their camp, he had to stay there. So rigorous were they with lepers that they compelled the person attacked with this disease to cover himself with a sheet, leaving only the eyes showing, and to carry a bell which by its ringing would announce to passers-by his presence, and to give them opportunity to flee in time to avoid infection. Civilly, the leper was considered dead. Property passed to his heirs; his wife remained free to contract marriage, and when he left for the lazaretto, prayers were said and a shovel of dirt was thrown after him to make the ceremony complete.

The conditions found in the Lepers' Colony of Puerto Rico are even worse, because, although in that epoch those who suffered from this disease were persecuted, they could still move over a larger extent of territory, and could communicate with the outside

world and ask and receive aid in case of emergency, a cyclone for example; but on that island under such conditions they would be abandoned to the mercy of God.

There is another matter of great moral importance for the department of health and for society, which the committee ought to touch upon, namely, the practitioner charged with watching these patients and over order and [214] discipline in the colony, is not able alone and especially at night with all his efforts to prevent clandestine communications between the leprous men and women. The colony might be converted into a brothel, and if the theory of the heredity of this disease is true, the result would be that—contrary to the direction of our efforts—we would be contributing to the perpetuation of the race of lepers.

In consequence of the emanations of the sea and the great quantity of sodium chloride which constantly saturates the surroundings in that island, it may be that, acting on the ulcers of the skin and of the mucosæ as an electrolytic and dialytic agent, it aggravates their suffering by preventing the cicatrization of the ulcers. It may be that this new idea deserves study.

On the other hand, the means of communication with this island are not only bad but perilous to the life of those who expose themselves to traveling in small boats across an arm of the sea always agitated and wild. From this cause several persons have perished, among them an employe of this department. And these facts make it impossible to find a physician disposed to visit the island daily, which is to be desired if we wish—as we ought—to attend the lepers in an efficient manner.\*

[215] The leprosarium ought to possess all the conveniences and modern equipments for the care and treatment of the disease and for maintaining the patients in good physical and moral condition.

Leprosy is not according to any concept invariably fatal, and we ought to organize the asylums for lepers on the same plan as the modern sanatoria for tuberculosis, so that they can be cared for and educated by the same methods that are adopted for the tubercular.

Therefore, and as a result of our investigation, we recommend, that, through the commissioner of health, the legislature be requested to transfer the Lepers' Colony to a suitable location on the Island of Puerto Rico, where may be installed a modern sanatorium

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\* Some general statements about leprosy omitted.—Translator.

for lepers. We further recommend that there lepers should be treated in accordance with the precepts of modern sanitation and with the means which therapeutics offers us, and that this disease be studied and investigated in a scientific manner, since we do not know how it is transmitted nor do we have an effective remedy for curing it. It might happen that by constant work and by putting faith in God we could succeed in surprising the world with a discovery of great utility to humanity.

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## COMMUNICATION

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### BUREAU OF THE PUBLIC HEALTH SERVICE.

Washington, June 5, 1920.

*To the Editors, New Orleans Medical and Surgical Journal:*  
*Sirs:*

On account of the large number of arsenic preparations which are being exploited for the treatment of syphilis, the United States Public Health Service has considered it desirable to issue a circular letter, copy of which is inclosed, discouraging the indiscriminate use of untried preparations.

Attention is especially invited to the fact that provision is made for the experimental use of any preparation under conditions which will make the results of such experiment available to others than the physician immediately concerned.

I shall be glad to have you give the circular letter and this letter of transmission publicity.

Very truly yours,

H. S. CUMMING,

Surgeon General.

#### BUREAU CIRCULAR LETTER No. 219.

Medical Officers, U. S. Public Health Service and others concerned:

Your attention is invited to the extensive exploitation through advertisements in professional journals and otherwise of various arsenic preparations which are not related to the arsphenamine group. The preparations referred to are sold with claims in regard to their value in the treatment of syphilis, which are unwarranted.

In the opinion of this office it is in the interest of all concerned that the subcutaneous, intramuscular or intravenous use of arsenic in the treatment of syphilis be confined to preparations of the arsphen-



mine group as these agents are of established value and are produced under the regulations of the Public Health Service. The following firms are now licensed for the manufacture of arsphenamine and neo-arsphenamine:

Dermatological Research Laboratories,  
1720 Lombard Street,  
Philadelphia, Pa.

H. A. Metz Laboratories,  
122 Hudson Street,  
New York, N. Y.

Diarsenol Co., Inc.,  
Buffalo, N. Y.

Takamine Laboratories,  
Clifton, N. J.

The Lowy Laboratory, of Newark, N. J., has been granted a license to prepare a stable solution of arsphenamine.

It is not the desire of the Bureau to limit clinicians in the choice of agents of recognized worth but in the case of arsenic preparations, not members of the arsphenamine group, the available evidence indicates that their routine use is inadvisable in the treatment of syphilis. If it is desired to use any of these preparations in a purely experimental way previous authority from the Bureau should be secured. Applications for this authority should be accompanied by a statement as to the composition of the drug including the structural formula and the reason for its use. All information available on the value of the preparation should be forwarded.

Receipt of this circular should be acknowledged and marked "**V. D. Division.**"

H. S. CUMMING,  
Surgeon General.

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## BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Sect'y-Treas.

The Orleans Parish Medical Society gave an informal dance, on Wednesday, June 23, 1920, at its old domicile 141 Elk Place, just as a farewell to the old home and to have the ladies remember it with the same fond memories that are stamped in the minds of each and every member of the Society.

The halls and rooms of the domicile were very tastefully decorated, numerous palms and varied species of foliage lending a most pleasing and artistic touch to the scene of merriment. Harmonious reflections of the rainbow, indicated by the beautiful sum-

mer gowns of the fairer sex, glinted here and there as they tripped fantastically to the strains of an extensive orchestra.

Nature, as though in marked approval of the event, lent her cooling Southern breeze throughout the evening, and, aided by the most choice refreshments, thereby changed a much-feared warm summer evening to one delightful beyond all anticipation.

For many, particularly the dancers, the evening came to a close much too soon, and I might add that no one who participated in the pleasures of the occasion will ever forget June 23, 1920, and the "Old Home" of the Orleans Parish Medical Society.

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## NEWS AND COMMENT

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**TULANE COMMENCEMENT.**—The eighty-fifth annual commencement exercises of Tulane University was held on Wednesday, June 9. An interesting program was arranged, which included a statement by president A. B. Dinwiddie on the financial status of the university and an appeal for funds to form an endowment to carry on the work of education. The session just closed proved one of the most successful in the history of Tulane, there being an unusually large number of graduates in all the colleges and schools of the institution. In the college of medicine the number of graduates receiving degrees were as follows: School of Medicine, Doctor of Medicine, 81; School of Pharmacy, Graduate in Pharmacy, 10; Pharmaceutical Chemist, 1; School of Dentistry, Doctor of Dental Surgery, 3. The attendance of the Graduate School was the largest in its history. Three hundred and seventeen were registered, representing 33 states and four foreign countries. Among the number were 16 vocational students under the direction of the Federal Board for Vocational Education.

**TULANE BANQUETS.**—On June 6 Tulane Alumni Association tendered a banquet to its members, and on June 7, Parke Davis & Co., were hosts of the medical graduating class. Interesting and instructive addresses were delivered on both occasions, being enjoyed to the fullest extent by all present.

**CIVIL SERVICE EXAMINATION.**—The United States Civil Service Commission announces an open competitive examination for

junior physiologist, on July 6, 1920. The salary attached is \$2,000 per year and quarters for single employee, and vacancies in positions requiring similar qualifications, at this or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill vacancy by reinstatement, transfer, or promotion. Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., the Secretary of the United States Civil Service Board, Customhouse, in their district. Applications must be filed with the Civil Service Commission, Washington, D. C., prior to the hour of closing business on July 6, 1920.

**MILK PROFITEERS TAKE TERRIFIC DEATH TOLL.**—Profiteering in milk is responsible for the death of hundreds in Vienna. Statistics gathered by the American Red Cross show that 50,000 persons are suffering from influenza in the Austrian city, and three-fourths are unable to obtain medical attention, deprived of medicines and nourishing food. Milk is virtually unobtainable for any but the rich, who are paying as much as \$10 a quart to profiteers. When American relief workers in Vienna called the attention of the city authorities to the appalling mortality the officials replied that the impoverished state of the city treasury rendered impossible any organized and effective measures to suppress profiteering.

**ANOTHER SANATORIUM FOR TUBERCULOUS SOLDIERS.**—According to an announcement by Surgeon General Hugh S. Cumming, the magnificent tuberculosis sanatorium operated by the Army authorities at Fort Bayard, N. Mex., has been transferred to the U. S. Public Health Service, and will be available for treating discharged, disabled soldiers. The Sanatorium will provide 1,000 additional beds for the care of tuberculous patients. The present sanatorium at Deming will be held in reserve, especially for winter use. At Fort Bayard the Public Health Service will treat only ambulatory cases in which the prognosis is favorable.

**NATIONAL RESEARCH COUNCIL ELECTS OFFICERS.**—The National Research Council, a cooperative organization of leading scientific and technical men of the country for the promotion of scientific research and the application and dissemination of scientific knowledge for the benefit of the national welfare, has elected the follow-

ing officers for the year beginning July 1, 1920: Chairman, H. A. Bumstead; First Vice-Chairman, C. D. Walcott; Second Vice-Chairman, Gano Dunn; Third Vice-Chairman, R. A. Millikan; permanent secretary, Vernon Kellogg; treasurer F. L. Ransome. The Council was organized in 1916 under the auspices of the National Academy of Sciences to mobilize the scientific resources of America for work on war problems, and reorganized in 1918 by an executive order of the President on a permanent peace basis. It has recently received from the Carnegie Corporation, an endowment of \$5,000,000 part of which will be used in erecting a suitable building in Washington for the joint use of the Council and the National Academy of Sciences. Other gifts have been made to it for the carrying out of specific scientific researches under its direction.

MEETING GASTRO-ENTEROLOGICAL SOCIETY.—The annual meeting of the American Gastro-Enterological Society was held in Atlantic City, May 3 and 4, and the following officers were elected for the year 1920-21: Dr. Joseph Sailer, Philadelphia, president; Drs. Allan A. Jones, Buffalo, and James C. Johnson, Atlanta, Ga., vice-presidents; Dr. Frank Smithies, Chicago, secretary (re-elected); Dr. Horace W. Soper, St. Louis, recorder, and Dr. Clement R. Jones, Pittsburgh, treasurer.

AMERICAN SURGICAL ASSOCIATION ELECTS OFFICERS.—The forty-first annual meeting of this association was held in St. Louis, May 3 to 5 and the following officers were elected: President, Dr. John B. Roberts, Philadelphia; vice-presidents, Drs. Harvey G. Mudd, St. Louis, and James F. Mitchell, Washington, D. C.; secretary, Dr. John H. Gibbon, Philadelphia (re-elected); treasurer, Dr. Charles H. Peck, New York City, and recorder, Dr. John H. Jopson, Philadelphia (re-elected).

MEETING AMERICAN PHYSICIANS' ASSOCIATION.—The annual meeting of this association was held in Atlantic City, N. J., May 4 and 5. Election of officers resulted as follows: President, Dr. W. S. Thayer, Baltimore; vice-president, Dr. H. C. Moffitt, San Francisco; secretary, Dr. Thomas McCrae, Philadelphia; recorder, Dr. Thomas R. Boggs, Baltimore, and treasurer, Dr. Joseph A. Capps, Chicago.

NERVOUS AND MENTAL DISEASES RESEARCH ASSOCIATION FORMED.—This association was recently formed on the initiative



of the New York Neurological Society, and has been organized to promote research in neuro-psychiatric diseases. It is planned to hold annual meetings, at which only one subject will be discussed. A commission will conduct the meetings whose members will act as an investigating body. At the conclusion of the meeting the commission will prepare and publish only such material as it sees fit. Subjects will be given out from one to three years in advance of each meeting. New York City has been chosen for the first meeting, to occur late in December, 1920. The chairman of the organization committee is Dr. Walter Timme, New York City; Dr. Frederick Tilney, New York City, has been chosen chairman of the committee on arrangements for the first annual meeting.

**COLLEGES COMBINE.**—Maryland State College of Agriculture and the Maryland School of Medicine have been combined under the name of University of Maryland. This gives the new institution a college of arts and sciences, military school, and schools of medicine, dentistry and pharmacy. An appropriation has been made by the legislature of \$42,500 each year for the medical school for the next two years, and an additional appropriation of \$203,000 for building and equipment.

**NEW DEAN OF OREGON UNIVERSITY APPOINTED.**—Dr. Richard B. Dillhunt, of Portland, Oregon, formerly assistant dean, has been appointed dean of the medical department of the University of Oregon, to succeed the late Dr. K. A. J. Mackenzie. Increased facilities for teaching and research work with construction of special hospitals have been proposed.

**MEETING MISSISSIPPI STATE MEDICAL ASSOCIATION.**—The thirty-third annual meeting of this association was held in Jackson, May 11 and 12. The following officers were elected; President, Dr. John W. Barksdale, Winona; vice-presidents, Drs. Horace H. Kinney, Okolona; William A. Johns, Corinth, and Lawrence B. Hudson, Hattiesburg; secretary, Dr. Thomas M. Dye, Clarksdale (re-elected); treasurer, Dr. James M. Buchanan, Meridian.

**CLINICAL SURGEONS OF TEXAS.**—This is the name of a new medical organization recently formed in Texas, and is a branch of the American College of Surgeons. Officers selected are as follows: President, Dr. Bacon Saunders, Ft. Worth; secretary, Dr. W. B. Thorning, Houston; councilor, Dr. W. B. Russ, San Antonio.

YALE RECEIVES GIFT.—The General Education Board of New York has donated \$1,000,000 to the Yale University endowment fund. The endowment is to be used in the development of the New Haven General Hospital through the medical school of the university.

HONORS FOR GENERAL GORGAS.—King George of England, recently conferred on Gen. W. C. Gorgas, the knight commandership of the Order of St. Michael and St. George.

AMERICAN PEDIATRIC SOCIETY MEETING.—The thirty-second annual meeting of this society was held in Highland Park, Ill., May 31 to June 2. Following are the officers elected: President, Dr. John Howland, Baltimore; vice-president, Dr. Charles A. Fife, Philadelphia; secretary, Dr. Howard C. Carpenter, Philadelphia; treasurer, Dr. Charles H. Dunn, Boston, and recorder and editor, Dr. Oscar M. Schloss, New York City.

FORWARD MOVEMENT OF QUEEN'S MEDICAL COLLEGE.—As a general movement forward, Queen's Medical College, Kingston, Ontario, has advanced all salaries and added six new professors to its faculty. The general hospital will be enlarged as about a million dollars are in sight for the work. It is thought now that it will not be necessary to remove to Ottawa as was contemplated a few months ago.

GENERAL MEDICAL CONGRESS.—Under the presidency of Prof. Minkowski, the thirty-second meeting of the *Deutsche Kongress fur Innere Medizin* was held in Dresden April 20 to 23. The present position of immunotherapy and chemotherapy in infectious diseases was one of the subjects discussed.

ITALIAN MEDICAL PRIZE COMPETITION.—A competition for the Humbert I prize of 3,500 liras for the best orthopedic work or invention, is announced by the Instituto Orthopedico Rizzoli, of Bologna, Italy. The competition is open to foreigners, and conditions may be learned by addressing the president of the institute. The competition closes December 31, 1920.

HOTEL DIEU STAFF ORGANIZES.—On June 15, the staff of the Hotel Dieu was formed into a permanent organization. Thirty-eight members were present, and it is planned to hold meetings monthly. Officers elected to serve for the ensuing year are: Dr.

Marion Souchon, president; Dr. Homer Dupuy, vice-president; Dr. H. W. E. Walther, secretary and Dr. L. A. Fortier, recorder.

THE COLORADO CONGRESS OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY will be held in Denver, July 23 and 24, 1920.

PERSONAL.—Dr. J. George Dempsey has been appointed statistician of the State Board of Health to succeed the late Dr. Ellis.

REMOVALS.—Dr. G. McG. Stewart, from St. Francisville, La. to Clinton, La.

Dr. H. Johnston, from Wilson, La., to Reymond Building, Baton Rouge, La.

Dr. A. F. Jones from Ararat, N. C., to Cameron, N. C.

DIED.—On June 18, in this city, Dr. Henry S. Bennett, of Jonesville, La., aged 40 years.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

**The Medical Clinics of North America.** W. B. Saunders Company. Mayo Clinics Number, November, 1919. Boston Number, January, 1920.

These two issues maintain the usual standard of excellence of the publication. The topics presented are representative of the problems actively discussed by the profession. For the most part, the easy style and conciseness of the clinics catch the attention of the reader and maintain it. There can be no doubt as to the educational merit of the case method—for such this series largely is. I. I. LEMANN.

**The Narcotic Drug-Problem,** by Ernest S. Bishop, M. D., F. A. C. P., 8 vo. pp. 158. The MacMillan Company, New York, 1920.

Dr. Bishop has made an earnest plea for the consideration of the drug addicts not as degraded "weak minded, deteriorated wretch, mental and moral derelicts" but as individuals suffering from a "definite physical condition, presenting constant and definite physical symptoms and signs, . . . . explainable by a mechanism of body protection against the action of narcotic toxins . . . .". He insists that they take their drug not usually for sensual gratification but for the relief of actual physical suffering caused by the withdrawal or lack of the drug. Some antidotal toxic substance has become the constantly present poison, and the narcotic drug itself has become simply the antidote demanded

for its control. Many drug addicts when kept supplied with their drug are able to hide their secret and, not showing any by-effects, are useful and respected members of society. They should not be placed in the position of the criminal and the vicious. The author's plan of treatment is first to bring his patient into the best possible physical condition both by permitting the minimal amount of drug sufficient and adequate to meet his needs and by attention to his general health, getting rid of all possible abnormalities, physical and psychical; then to conduct "as rapid a withdrawal as is compatible with my patient's reactive condition and the reactions of his disease." He hastens elimination but keeps "well away from exhausting purgation." Hyosein and belladonna and their congeners he regards as too dangerous to be used routinely, though he admits that they are at times useful in the treatment of addiction. In general, therefore, he is opposed to the Towns (Lambert) treatment or any other routine scheme. On the other hand, his own plan is so vaguely outlined as to be little satisfying even to one who is ordinarily opposed to dogmatic, rigid plans of treating disease. There is much reiteration of the author's view point and the work could profitably have been brought into smaller compass. The message the book carries is one well deserving the serious attention of the profession and it is expressed in a clear, readable and forceful manner.

I. I. LEMANN.

**The Diseases of Infants and Children**, by J. P. Crozier Griffith, M. D., Ph. D. W. B. Saunders Co., Philadelphia and London, 1920.

This complete work in two volumes should be found in the library of every physician. In recent years, so many books covering the subject of Pediatrics have been published, but it remained for this author to present so varied a subject from as many view points.

All topics are covered in their entirety. The many references covering the important subjects, the simplicity of expression, the systematized distribution, are only a few of the added virtues of this splendid and painstaking work.

C. J. BLOOM.

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## PUBLICATIONS RECEIVED

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**LEA & FEBIGER**, Philadelphia and New York, 1920.

**Principles of Human Physiology**, by Ernest H. Starling, C. M. G., F. R. S., M. D., Hon. Sc. D., F. R. C. P.

**Text-Book of Dermatology**, by J. Darier, M. D., authorized translation from the second French edition. Edited with notes by S. Poltizer, M. D.

**Pathogenic Microorganisms**, by William H. Park, M. D., and Anna Wessels Williams, M. D., assisted by Charles Krumwiede, Jr., M. D. Seventh edition, enlarged and thoroughly revised.

**A Manual of Physical Diagnosis**, by Austin Flint, M. D., LL. D. Eighth edition revised by Henry C. Thacher, M. S., M. D.

**A. Diabetic Manual**, by Elliott P. Joslin, M. D., second edition, thoroughly revised.

**A. Laboratory of Syllabus of Clinical Pathology**, by Charles E. Simon, B. A., M. D.



Note:—We note that in the April number of the **New Orleans Medical and Surgical Journal** you failed to put our name as the publishers of **Brown's Rules for Recovery from Pulmonary Tuberculosis**. Could you not make correction in your next issue?

Very truly,  
LEA & FEBIGER.

**F. A. DAVIS COMPANY**, Philadelphia, 1919 and 1920.

**Principles and Practice of Infant Feeding**, by Julius H. Hess, M. D., second revised edition. (1919).

**Regional Anesthesia (Victor Pauchet's Technique)**, by B. Sherwood-Dunn, M. D. (1920).

**W. B. SAUNDERS COMPANY**, Philadelphia and London, 1920.

**The Surgical Clinics of Chicago**, April, 1920, Volume 4, No. 2.

**P. BLAKISTON'S SON & CO.**, Philadelphia, 1920.

**Pharmaceutical Bacteriology**, by Albert Schneider, M. D., Ph. D.

**WM. WOOD & COMPANY**, New York, 1920.

**Cunningham's Manual of Practical Anatomy**, revised and edited by Arthur Robinson. Seventh edition. Volume second, Thorax and Abdomen.

**JOHN WILEY & SONS, Inc.**, New York, 1920.

**Manual of Psychiatry**, edited by Aaron J. Rosanoff, M. D. Fifth edition, revised and enlarged.

**BAIRD-WARD PRINTING CO.**, Nashville, Tenn., 1920.

**The Care and Feeding of Southern Babies**, by Owen H. Wilson, M. D. 1920.

**WASHINGTON GOVERNMENT PRINTING OFFICE**, Washington, D. C., 1920.

**United States Naval Bulletin**. Vol. 14, No. 2.

**Military and Naval Insurance, and Military and Naval Compensation Claims as a result of the World War**. June 30, 1920.

**U. S. Department of Agriculture, Service and Regulatory Announcements**. Supplements. Notices of Judgment under the food and Drugs Act. May 4, 1920.

**Public Health Reports**, Volume 35, Nos. 18, 19, 20, 21, 22.

**THE PANAMA CANAL PRESS**, Mount Hope, C. Z., 1920.

**Report of the Health Department of the Panama Canal** for January, February, March, 1919.

#### MISCELLANEOUS:

**Government by Default**. Address before the Association of Life Insurance Counsel, by Hon. Job E. Hedges, Gen. Counsel, Association of Life Insurance Presidents.

**On the Epidemic, Acute and Subacute Non-Suppurative Inflammations of the Nervous System Prevalent in the United States in 1918-1919: Encephalitis; Encephalomyelitis; Polyneuritis; and Meningo-Encephalo-Myeloneuritis**. Extracted from the **American Journal of the Medical Sciences**, by Lewellys F. Barker, M. D., Ernest S. Cross, M. D. and Stewart V. Irwin, M. D.

#### REPRINTS.

**Modern Scientific Views on the Pathologic Basis of Narcotic Drug Addiction**, by Christian F. J. Laase, B. S., M. D.

**MORTUARY REPORT OF NEW ORLEANS.**

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for May, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever			
Intermittent Fever (Malarial Cachexia)			
Smallpox	2	8	10
Measles			
Scarlet Fever	1		1
Whooping Cough	1	1	2
Diphtheria and Croup	1	1	2
Influenza			
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	28	38	66
Cancer	24	10	34
Rheumatism and Gout		3	3
Diabetes	2	1	3
Alcoholism	1		1
Encephalitis and Meningitis	2		2
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	13	7	20
Paralysis	2	2	4
Convulsions of Infancy			
Other Diseases of Infancy	7	5	12
Tetanus			
Other Nervous Diseases	1	1	2
Heart Diseases	41	20	61
Bronchitis	3	3	6
Pneumonia and Broncho-Pneumonia	17	16	33
Other Respiratory Diseases	1	1	2
Ulcer of Stomach	2	1	3
Other Diseases of the Stomach	1	2	3
Diarrhea, Dysentery and Enteritis	11	17	28
Hernia, Intestinal Obstruction	1	5	6
Cirrhosis of Liver	6	4	10
Other Diseases of the Liver	1	3	4
Simple Peritonitis			
Appendicitis	2	3	5
Bright's Disease	18	18	36
Other Genito-Urinary Diseases	9	8	17
Puerperal Diseases	3	5	8
Senile Debility	2		2
Suicide	2		2
Injuries	23	17	40
All Other Causes	27	15	36
<b>TOTAL</b>	<b>251</b>	<b>215</b>	<b>466</b>

Still-born Children—White, 17; colored, 22; total, 39.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 10.39; colored, 23.45; total, 13.98. Non-residents excluded, 11.95.

**METEOROLOGIC SUMMARY (U. S. Weather Bureau).**

Mean atmospheric pressure	29.96
Mean temperature	78
Total precipitation	4.08 inches
Prevailing direction of wind, southeast.	

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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## EDITORIAL

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### THE CURE OF MELANCHOLY.

Not long ago an earnest correspondent wrote a medical colleague, in all anxiety soliciting the way to obtain a cure for melancholy. What a world of philosophy is involved! The psychoanalyst might question this illusion, putting melancholy in its place as an exact entity among the "pathies" of his every day experience. The melancholic is seasonal and eccentric in his method, but, in a world so out of tune, he offers more than a mere analysis.

Shakespeare abounds in the borderland of melancholy—from Hamlet, the tragic Dane, to the Merry Andrew, in *Twelfth Night*, who experiences that "whirl-a-gig of time, which brings its own revenges."

What of him who in the forest studies maid and fool and finds philosophy in their unequal wit, and most time sits alone—Jacques, the victim of Rosalind's gibes in *As you Like It*.

The obliquity of a great era of a civilized world has left at the side lines those who find the struggle too hard, or who, moving on with the mass, are not strong enough to get all the vision.

The cure of melancholy, indeed! Why try to break thru the cloud which obscures the too brilliant sun—indifference without liability!

Responsibility for the world and its affairs is the day's work of the sane, and every day invites more labor; it is hard to step aside. A pleasant melancholy affords a good excuse. To him who fails in love, a quick disguise is melancholy; to her who likewise misses in the whirl of chance, indifferent compensation offers, and to her melancholy beckons.

Says Jacques (*As you Like It*): "It is a melancholy of mine own, compounded of many simples," \* \* \* "indeed the sundry contemplation of my travels, which, by often rumination, wraps me in a most humerous sadness."

In his *Anatomy of Melancholy*, Burton says that "Melancholy men of all others are the most witty."

Perhaps after all it is only the poets who have understood melancholy and the alienist has not held consultation with them in the study of this phase of disease. The poet says:

"Go! You may call it madness, folly;  
You shall not chase my gloom away!  
There's such a charm in melancholy  
I would not if I could be gay."

(Roger)

We have known of artists who felt this spirit of contrariety and who expressed their sense of gloom on grey, rainy days, by using such occasions to paint sunny pictures!

Dante has delicately put it that "there is no greater anguish of the human mind than in the midst of happiness to find remembered grief!"—an edge of melancholy uninvited.

When Macbeth invites the confidence of the doctor anent his spouse and advises that he should "with some sweet oblivious antidote cleanse the stuff'd bosom of that perilous matter which weighs upon the heart," the doctor replies:

"Therein the patient must minister to himself."  
And therein must lie the cure of melancholy.

"There is a pleasantness in being mad,  
Which none but mad men ever know."

(Dryden)



What is the cure of melancholy? Its etiology is as varied as the rays of a setting sun, and as intangible. To sit apart amid old sorrows and nurse them for the joy in their sadness; to pluck from childhood the sunbeam of happiness and treasure it until it fades; to glimpse the breath of a golden morning and have it break into a clouding day; to hear the melody of far away music and to weave it to memoried tunes; to meet the hurrying crowd of every day and, hurrying, forget the yesterdays and make no horoscope for the to-morrows—such are the disordered concatenations of melancholy which baffle cure.

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### DR. GORGAS.

Major-General William Crawford Gorgas, born in Mobile in 1854, died in London on July 4, 1920, mourned not only nationally but internationally.

He graduated in medicine in 1879 and entered into the service of his country as a surgeon of the army during the next year. He was president of the American Medical Association from 1909 to 1910 and was surgeon-general of the U. S. Army from January, 1914 up to the cessation of hostilities in the World War.

His fame, however, is due to his long and brilliantly successful work in sanitation. Serving as health officer of Havana during the first American occupation, he put into practice the measures for the control of yellow fever suggested by the discovery of the mosquito transmission of the disease by the Army Board headed by Reed. Not long after, the work under his charge resulted in a sanitary condition on the Isthmus of Panama which rendered practicable the digging of the Canal. Under the auspices of the British Government he studied pneumonia in the miners of South Africa, making valuable suggestions for its prevention. Again, he was commissioned comparatively recently by the Rockefeller Foundation to study yellow fever in Central and South America and to devise means for throttling it at its source.

By special act of Congress he was created Major-General for life in recognition especially of all he had accomplished as a sanitarian.

A quiet, modest Southern gentleman, he did much merely through the influence of his personality. Here in New Orleans, where we knew him well, he was much loved and will be sadly missed.

## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### IMPORTANCE OF THE EARLY RECOGNITION AND TREATMENT OF GLAUCOMA.

By D. T. ATKINSON, M. D., San Antonio, Texas.

There is probably no ocular disease in which a correct and early diagnosis is of more importance than it is in acute glaucoma. I know of no other condition in which a few days and sometimes a few hours of inappropriate treatment will produce such disastrous and irreparable results.

The largest per cent of these cases are seen first by the general practitioner, and it is of the utmost importance that he should be able to diagnose them correctly and without the loss of time if the integrity of the eye is to be preserved. The physician who passes his eye cases over with a hasty inspection, or who allows himself to be beguiled into the practice of prescribing eye washes for all eye disorders, will, sooner or later, make some error fatal to vision, which might have been avoided.

A routine treatment with some doctors is that of prescribing preparations containing cocain in all cases where the eyes are inflamed and painful. This is an exceedingly dangerous practice to say the least. Cocain dilates the pupil and, in glaucoma, dams up the already obstructed canal of Schlem, which results in a loss of the eye in a suprisingly short space of time. Atropin acts in the same way and is even a more dangerous agent for indiscriminate use than is cocain. A potent solution of either of these drugs used in an eye with glaucoma for twenty-four hours will damage it past all possibility of repair.

Within the last two years I have seen two cases of absolute glaucoma with total blindness resulting from this mistake. Not a month ago I saw a blind eye due to a glaucoma which had been mistaken for a conjunctivitis and a simple wash prescribed, the eye being permanently disabled before an aggravation of the symptom prompted the attending physician to make a more thorough exami-

nation. Of course the wash in this case did no harm, but the sense of security established in the patient by the treatment, and perhaps by the assurance that the eye would soon be well caused him to accept his condition as a matter of course for days before requesting another examination, during which time the eye lapsed into a condition of complete glaucoma with all hope of restoration lost.

I do not mention these cases in a spirit of criticism, for I have not forgotten that seven years ago, while doing my first practice, I made an error similar to the ones I have recited. To me, however, these cases have served as valuable object lessons in impressing the extreme importance of a correct and early diagnosis in glaucoma, and the danger of prescribing for any eye condition until an accurate and positive diagnosis is made.

It is not my object in this paper to dwell at length upon all the symptoms presented in acute glaucoma, but as many of its symptoms and those of "sore eyes" or simple conjunctivitis are similar, and as glaucoma may simulate iritis, the treatment of which is fatal to an eye with glaucoma, I will mention only a few points which are necessary to be observed in making a diagnosis.

The intraocular symptoms present in glaucoma are of little importance from a general practitioner's stand point, for they can only be elicited by an ophthalmoscopic examination in a dark room. Facilities for making this examination are not ordinarily found in the physician's office, and it takes a great deal of practice to perfect one in the use of the ophthalmoscope. The diagnosis from external evidences is not difficult if the classical symptoms of the disease, which may be determined from ordinary inspection, are kept well in mind.

The disease is usually ushered in with pain, which radiates along the branches of the fifth nerve. Though this is an almost constant symptom, it is more or less misleading, for we often have described to us a similar pain in corneal ulcer and iritis. It is well to remember that the pain in corneal ulcer and iritis is more periodic than in glaucoma, and in iritis is worse during the early morning hours.

An examination of the globe elicits an increase in tension. This is characteristic and should be sought for in all inflamed eyes. It may vary all the way from stony hardness to a little more than usual resistance under palpation. In conjunctivitis there

is no change in intra ocular tension and in iritis the tension is usually unaltered.

In glaucoma the iris is pushed forward, sometimes almost obliterating the anterior chamber. This occurs in no other acute eye disease. The pupil is contracted in iritis and in conjunctivitis it is not affected. A good point in diagnosis is the unsensitiveness of the cornea. In nearly all cases it may be touched without the least sensation being produced. In no other condition, where some form of paralysis does not exist, is this symptom found. The cornea has a steamy appearance and looks like glass that has been breathed upon. In iritis the cornea is sometimes hazy, but the haziness is due to its posterior surface being studded with deposits. This can easily be differentiated. The appearances of the cornea in the two conditions are never alike. There is usually profuse lachrymation but the secretion is clear and causes no gluing together of the lids in the morning as is the case in conjunctivitis. The injection in glaucoma is general but usually superficial. In iritis it is pericorneal and deep.

In addition to these points in diagnosis, it is well to remember that in glaucoma and iritis one eye only is affected as a rule, and that in conjunctivitis both eyes are almost always attacked simultaneously. Also that conjunctivitis is common at all ages, that glaucoma seldom occurs before the fortieth year, and that iritis is rarely seen in childhood.

The following table may not be amiss in giving the points between glaucoma, iritis and conjunctivitis:

Glaucoma.	Iritis.	Conjunctivitis.
Pupils dilated.	Pupil contracted.	Pupil unaffected.
Patient usually over 45 years old.	Usually under 45 years.	Occurs at all ages.
Tension always increases.	Tension seldom increased.	Tension never increased.
Anterior chamber shallow.	Anterior chamber normal.	Anterior chamber normal.
Cornea anesthetic.	Not so.	Not so.
Lids do not glue together.	Lids may glue together.	Lids glue together.
Injection general but superficial.	Injection pericorneal, but deep.	General injection.

In nearly all cases of glaucoma operative interference is indicated, and after the diagnosis is made, the general practitioner usually turns to the specialist for help, but sometimes circum-



stances make immediate operation impossible, and some form of treatment must be instituted. In this paper only the general principles of non-operative treatment will be dealt with.

In the non-operative treatment both local and general measures should be employed. Under the local treatment the first essential is contraction of the pupil. Eserine is the most reliable and satisfactory drug for this purpose, and is usually applied in the strength of two grains to the ounce of distilled water. In addition to the use of eserine hot fomentations should be applied to the temple. Morphin may be necessary for relief of pain. It is not intended that this line of treatment should be looked upon as curative in glaucoma cases. These should be taken however, with a view to relieving the tension and allaying the symptoms till an iridectomy can be performed.

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## SPASTIC CONSTIPATION.

By J. M. PERRET, M. D., New Orleans.

Constipation is undoubtedly "the commonest ill that human flesh is heir to." Important as the condition is, it is not usually accorded the consideration which it deserves. It is such a frequent complaint and as the evil effect resulting from it are not always immediately evident, it is not taken seriously.

Again as the causes that produce it are so numerous and varied and not always at once clear, many practitioners content themselves by dismissing the patient with a prescription for a purgative. The natural result is that frequently not only is the trouble not cured but often aggravated.

The object of this brief paper is to show the necessity of making a correct diagnosis, if we wish to cure the patient. Lack of care makes us make more mistakes *than lack of knowledge*. If we take the trouble to obtain a good clinical history, make a thorough physical examination, and submit the gastro-intestinal tract to a barium meal examination with the X-ray, we ought to be able in the majority of cases to arrive at a correct diagnosis.

Careless, slipshod therapeutics will avail us but little, if the cause of the constipation is due to a lack of gastro-hepatic secretion. It is evident that drugs acting on the intestines will not do any good; again if the trouble is due to atony of the bowels, anti-spasmodics will not help. Some cases are due to reflex causes

from a diseased appendix, others to kinks which may call for surgical intervention. Hence the necessity of getting at the bottom of the trouble and trying to remove it.

No attempt is here made to list all the causes of constipation which may be found in any text on the practice of medicine.

The importance of the spastic type of constipation, which is well recognized, is not often enough borne in mind, with the result that these cases are often missed. With the more frequent use of the X-ray, however, more of these cases are being discovered. Of course it may not be practicable for every one to have access to an X-ray laboratory or the patient may not be able to afford to pay for such an examination. In such cases when we suspect spasmodic constipation we ought to try the therapeutic test with anti-spasmodic drugs, the best of which is tincture of belladonna.

Spastic constipation may be due to a marked local vagus stimulation or to an increased irritability of the neurones supplying the intestinal muscles. Reflex causes are diseases of the eye, lungs, appendix, stomach, liver, gall-bladder, pancreas, kidneys, etc. The stimulus is carried by means of the vagus nerve, hence the value of drugs of the belladonna group which antagonizes its action.

The following cases are introduced to show that the condition was relieved only after the cause had been sought for and the appropriate treatment instituted. In two of the cases it was medical; in one surgical.

**Case No. 1.**—C. F. M., white male, age twenty-four, was seen on March 5, 1918, complaining of constipation.

Past history was irrelevant.

Family history—Father frequently suffered from diarrhea.

The patient's trouble dates back five years. At intervals of three to six months he would suffer from attacks of marked constipation, during which his bowels would remain a week to ten days without moving. At such times he would feel drowsy, irritable, suffer from headaches and would have severe cramps and vomit. He would feel so sick that he would have to remain in bed from one to three weeks.

During these years he has been under the care of various physicians and has been a constant user of purgatives and tonics and has had only temporary relief.

Physical examination revealed an intelligent, high strung, somewhat emaciated, sallow complected young man, with exaggerated knee jerks. The chest, abdomen and rectum were negative. Weight 140 pounds.

Laboratory findings—Urine analysis showed a slight trace of indican. Wassermann reaction was negative.

Blood examination—Hemoglobin 80%. Red blood cells 5,900,00 per c. mm.

Differential count—Lymphocytes 28, eosinophiles 3, neutrophiles 69. There was X-ray evidence of a root abscess of upper left lateral incisor. X-ray study of gastro-intestinal tract.

12 hours plate. Dilatation of cecum. Massing of barium in head of cecum and hepatic flexure. Spasticity of transverse colon.

24 hours plate. Barium massed at hepatic flexure. Spasticity of upper part of colon and sigmoid. Small amount of barium has reached rectum.

48 hours plate. Barium massed in transverse colon. Spasticity of sigmoid.

72 hours plate. Barium seen in sigmoid and rectum.

109 hours plate. Barium still present in sigmoid and rectum.

**Treatment**—The abscessed tooth was extracted.

The patient had an error of refraction. He was referred to the oculist and had his glasses changed.

Dietetic—Oatmeal, fats and fruits, and a glass of water on getting up and on retiring were advised. Liquid alboline, an ounce in the morning and in the evening and tincture of belladonna, ten minims, three times a day, were prescribed. Patient soon began to improve. Bowels moved readily and he felt better. He was told to watch his diet and keep up the liquid alboline.

Subsequent history—He was seen two months later and had gained five pounds and was feeling well. He has continued his liquid alboline and has two or three stools daily. He was advised to diminish gradually the liquid alboline.

**Case No. 2**—M. A. L., white male of thirty years was seen November 1, 1918 and complained of headache, abdominal cramps and constipation.

Family history was negative.

Past history—Mumps and measles in childhood. Malaria at age twenty-six. During the past four years he has had three to four attacks of diarrhea, having about six watery stools during the twenty-four hours. According to the patient these attacks are brought on by indiscretion in diet. During these he would pass mucous strings about six inches long. It would not be necessary for him to take any treatment as he would be well in a day.

Venereal history—Six years ago after an inoculation period of three weeks he developed a sore on penis. This was followed by skin eruption which lasted one week and also suffered from sore throat. He remained under anti-syphilitic treatment for six months.

Present illness dated back to a week before I saw him. He has never had a similar trouble, his bowels always having moved once a day. For preceding four days he has had a daily enema and these were always returned clear. During this time two ounces of castor oil were given every day and would be followed by a single soft yellow stool. He complained of abdominal pains just below navel and said that it was continuous and at times would become cramp like. He described the cause of the pain as starting from the right upper abdomen and traveling across to left upper part of abdomen.

Physical examination showed a nervous patient with a very prominent lower abdomen. The rest of the examination was negative.

Laboratory examinations—Urine contained a large amount of indican. Wassermann reaction was plus x.xx.

The stools were negative for parasites and ova.



From the patient's history the case sounded very much like one of spastic constipation and he was referred to the X-ray laboratory for study of his intestinal tract. It was evident that purgatives were not doing patient any good and if we wanted to relieve him we would have to try to locate the cause of his constipation.

X-ray study of gastro-intestinal tract.

6 hour plate. No gastric residue. Small intestine free of barium. Appendix seen. Cecum and ascending colon well filled. Marked spasticity of transverse colon. Some spasticity of sigmoid.

29 hour plate. Cecum full of barium. Residue in appendix which appears to be bulbous and kinked. Considerable angulation at splenic flexure.

**Treatment**—The patient was put on liquid albolene for a week, tincture of belladonna for two weeks and made a good recovery. The bowels moving regularly when these were discontinued.

Anti-syphilitic treatment was also instituted.

**Case No. 3**—F. C. O., white adult male, was seen on June 4, 1919 and complained of constipation.

In August, 1918, he had abdominal cramps, constipation and headache for a week. In the Spring of 1919 and up to the time that I saw him his condition was getting worse, although he said that he ate fruits and drank lots of water. The abdominal soreness and headaches increased. The soreness was mostly in the left side but at times he had a dull burning pain in the right lower abdomen. He tried mineral oil without results. Large doses of castor oil and epsom salts were the only things that would cause his bowels to act, after these he would feel good for a day, but the old trouble would begin again. He was carefully examined, but examination was negative.

X-ray examination.

48 hour plate. Stasis in colon. Spasticity of transverse colon.

**Treatment**—Exercise, diet, liquid albolene and tincture of belladonna were tried for a period of six weeks without satisfactory results. The patient was told that the appendix might be the cause of his trouble. Having suffered so much discomfort he asked that he be operated upon.

On July 29, 1919, laparotomy was done by Dr. W. C. Payne of Pensacola.

A slightly diseased chronic appendix was found and removed. Exploration of rest of abdomen was negative. After the operation was over we were afraid that we would not accomplish much; in this however, we were deceived.

Subsequent history—February 15, 1920, patient reports that he is well.

The following table may be of interest:

Evidence of indican in 780 routine analyses at U. S. Naval Hospital, Pensacola, 1918.

No. 1 indicates a trace, No. 6 a very large amount. Other figures indicate a corresponding variation in account.

Positive 450 cases, 57%.

Negative 330 cases, 42%.

Indican No. 1—103 cases, 13%



- No. 2— 8 cases, 1%.  
No. 3—191 cases, 24%.  
No. 4— 7 cases, 0.8%.  
No. 5— 2 cases, 0.2%.  
No. 6—139 cases, 18%.

The liberal amount of protein allowed in the Navy ration will explain the above apparently high indican incidence.

#### SUMMARY.

1. Careful search for the underlying cause of the constipation.
2. Utilization of X-ray.
3. Tincture of belladonna and liquid alboline in spasmodic cases in which no organic disease is found.
4. Surgery when indicated.

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### LEPROSY IN THE UNITED STATES.\*

By ISADORE DYER, Ph. B., M. D., New Orleans.

In the discussion of the occurrence of leprosy in the United States I have always contended that estimates have been too low. Even with the admirable conclusions presented by Dr. Hoffman at the last meeting of the A. M. A., I believe the figures presented are too conservative. Official records carry only officially known cases and disregard the cases at large and those coming under the care and observation of individual physicians, with private patients, who do not always report these.

We need more publicity in the investigation of leprosy to awaken interest in its study. For the past twenty-five years I have been an active proponent of the study of leprosy in this country. When the Berlin Conference of 1897 promulgated its conclusions, the United States was one of a few civilized countries without provision for leprosy; it has taken twenty years for some action and there is still delay in furthering it.

Dr. Hoffman has shown the evident failure of the quarantine officials to recognize leprosy in persons entering this country. The apathy of New York and the indifference of most other states has allowed a dissemination of the disease throughout this country which

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\* Discussion of Paper by Dr. Frederick L. Hoffmann, of Newark, New Jersey. This discussion was not accepted by the *Journ. A. M. A.* because it contained over 400 words.

now includes incidence in twenty states, with focuses in the North, East, South and West and, also, in the Central States.

It is futile in studying the spread of leprosy to argue that any climate or region possesses immunity. If Norway, Iceland, Greenland, Russia, India in its hill country and coast lines, harbor lepers, and tropical and semi-tropical countries have the disease as well, why should some of the United States attribute the lack of leprosy to some favored dispensation in climate? The correlative facts also disprove this. Nearly thirty years ago lepers were brought to Minnesota from Norway, under the belief that the climate would cure them. Most of them were bettered, but died in due course. It took over twenty years for a new case of leprosy to arise in Minnesota, but it did arise! In 1897, returning from the Berlin Conference, I arrived in New York and read in the morning papers that the Academy of Medicine had the night before passed resolutions declaring leprosy was not contagious and it was not necessary to segregate lepers in New York. With me, I brought resolutions of the Berlin Conference (made up of 150 leprologists from all over the world), which positively declared leprosy contagious and recommended to all governments that segregation was the only way of combatting the spread of the disease.

In December (26th), 1910, at a leprosy conference at the Academy of Medicine in New York, seventeen lepers were presented, *four of whom had been born in New York* and had never been away from New York or its vicinity.

Louisiana has offered the best field for the study of leprosy, because, for over a hundred years, some notice has been taken of this disease. The study of leprosy in Louisiana has shown genealogical relation in the spread of the disease. Whole families have been infected; parents, children, cousins, with clear histories of intimate domestic and household association! More than one instance records children first affected, then a few years after, one or another parent showed the disease. I know of three cases in Texas who contracted the disease from close household contact with a leper who moved to Texas from St. James Parish in Louisiana.

It is purely an academic argument to contend that leprosy is not contagious, just because the postulate of Koch has not yet been fully worked out. Organisms peculiar in leprosy have been found and these have not been found in other diseases. While no certain culture of the leprosy bacillus has yet arrived, the morphological similarity

with the tubercle bacillus argues that it is only a matter of finding a proper technic.

Dr. Hoffman has laid stress on the inadequate consideration of leprosy by scientific men. This consideration has been left to the few who have blazed the trail.

In 1899, I publicly stated that we had cured twelve cases of leprosy in Louisiana. This was received by the medical press as an insult to the intelligence of the profession, which had already *decided* that leprosy was incurable. In a recent paper Dr. Ralph Hopkins, the present medical attendant of the Louisiana Leper Home, made the statement that the Home, since 1902, had discharged 34 patientes as arrested or cured (with four relapses).

The practice of condemning a leper as an offense against society, thru which for centuries he has been outcast, makes it difficult to convince even the professional man that there is hope for the leper on earth, and that he need not wait until he meets eternity to gain his salvation. The Louisiana Leper Home was started in 1894 as a hospital for the treatment and a home for the care of lepers. In 1896 the Board in charge believed the province of the Home was more of an asylum and so began to conduct it. Dr. Hoffman's analysis of admissions to the Louisiana Home shows the result of this policy, for immediately and until 1902 the annual admission grew smaller in numbers. The institution as a home and asylum failed to attract voluntary segregation, but as soon as proper treatment was again offered most of the inmates came voluntarily.

The bearing of treatment on segregation is of great importance. As soon as compulsory confinement is required by state law, the leper seeks and usually finds concealment and his condition is rendered worse thereby. If state legislation makes provision for adequate treatment and this is made known, the leper will seek the relief in spite of the deprivation of his liberty. In Louisiana not one case in fifty will decline to accept the Home and they are usually inspired from the start with the hope of cure. When government hospitals arrive and adequate provision is made for the cure of leprosy, these asylums will be sought for and can render large service in relieving these poor souls, while the segregation will reduce contacts and thereby prevent leprosy spread. The disease took nearly four hundred years to reach its total of something like 20,000 in Continental Europe in the 12th century, and Dr. Hoffman's statistics for India, Hawaii and the West Indies show what figures may

be reached in modern times. In 1897, the United States of Colombia and Japan reported some 20,000 lepers, and in China they are known to be so numerous that it is said to be a common sight to meet the leper, ringing his warning bell along the highway.

The long prevalence of leprosy as a neglected disease, for several thousand years, has made of it an insidious menace, because of its concealment, even in countries where asylums are afforded and the salvation of systematic treatment has not yet reached the vast majority of those afflicted. In Louisiana we go on curing our lepers, while, in most countries, those concerned are still experimenting.

The formula of treatment is so simple. The so called "Dyer Method" consists in a daily hot bath, raised to the highest temperature of endurance (usually not over 110° Fahr.); a three times a day strychnin pill (1/60-1/40 of a grain); a three times a day dose, before meals, of chaulmoogra oil (crude as it can be had in fluid form) beginning with three drops and running the dose up to the tolerance of the patient, usually from 50 to 80 drops, tho some patients take as much as 120 drops, or more, at the dose. The oil is best taken in capsules, tho it may be mixed with cod liver oil, olive oil, or may be taken in milk or with milk of magnesia in a shaken mixture or emulsion.

The offer of cure to the leper will bring him to the place where such a blessing is afforded, and the government of this country should conduct its asylum or asylums with a view to making this offer a part of the publicity plan.

We have experimented at the Leper Home for the past 26 years—with chlorate of potassium, hoang nan, sera and vaccins; the original chaulmoogra oil was split into its fat acids, essential oil and the residue of these were experimented alone and in combination. Antivenomous serum was used first and chiefly by us—and a number of those much vaunted remedies, e. g., red mangrove bark—but in all these no treatment has met with any success except the treatment outlined above, which combined the Beuperthy and the Japanese hydrotherapy with the chaulmoogra oil, which was known and used in India, easily for 300 years before we employed it, the only difference being that in 1890 the dose of chaulmoogra oil was set at 3 to 15 drops, and our work has shown that no results can be had under a dosage of 40 to 80 drops or 120 to 240 drops a day, and the more oil patients take the sooner they show results.

Leprosy has large similiarity to tuberculosis in its development



and course and its effect on the internal organs is likewise similar. The arrest of tuberculosis is acknowledged; the arrest of leprosy is easier and more complete when the disease is taken early, therefore leprosy should be acknowledged as a curable disease in about the same proportion as this recognition is given to cures in tuberculosis.

Those concerned with the administration of public health and those interested in human welfare should be grateful to Dr. Hoffman for his continuous and humane efforts for the control and extinction of leprosy, the oldest and most odious scourge now laid upon us.

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### A CASE OF MULTIPLE LESIONS IN LEISHMANIOSIS.

By DR. OCTOVIO TORRES, Bahia, Brazil.

(Translated from the Portuguese for the *Journal* by Dr. A. McShane, New Orleans.)

The case we are about to describe is interesting simply from the large number of lesions which the patient presented, for we believe that no parallel case has ever been placed on record.

When in 1916, we presented to the Medical Society of the Hospitals of Bahia a case of leishmaniosis with symmetrical multiple lesions, we said: "Jeanselme stated that the lesions of leishmaniosis are generally five or six in number, very exceptionally attaining the number of forty in the same individual." In Rio de Janeiro, Dr. Dutra e Silva, the eminent assistant in the Institute of Maguinhos, observed a case with about 100 lesions; and we recall that Alfredo da Matta, of the hospital of Manaus already spoke of a case that had a hundred odd lesions. It appears then, that the present case presents more lesions than any other heretofore mentioned.

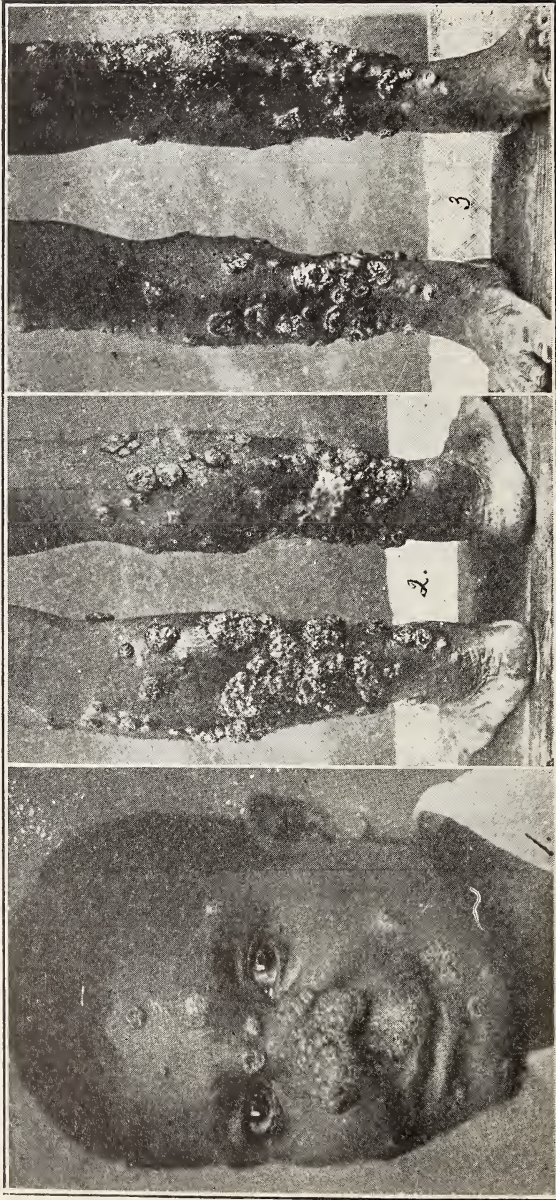
The patient's lesions are in various stages of evolution, from the very small ones (called "espinhas" by the patients) up to the large ulcers having a diameter of three centimeters, such as we found on the patient's left hand.

The lesions are monomorphic, giving the impression of a case of boubas.

We made sections of the lesions, and found Leishman bodies. Many of these preparations were exhibited to the Medical Society of the Hospitals of Bahia.

By means of the frozen sections it was shown that there was no associated morbid state, which was also borne out by the treatment.

In the clinical history of this patient, there appeared certain features which some authors have grouped in their description of boubas; the primitive lesion appears somewhat later than in the



Illustrating article on Leishmaniasis (248 lesions) by Dr. Torres.

other disease; the lesions are monomorphous; they occur in superficial layer of the skin; the general condition of the patient is good; there are no lesions of the mucosæ (mouth, nose, throat). But we find all this in leishmaniosis, and when a microbiological examination is not possible, we can make the diagnosis only by exclusion.

We made inoculation of products of the lesions in blood, with negative results.

Syphilis was excluded not only by a careful examination, for the patient had no symptoms of this disease, but also by a negative Wassermann; furthermore, monomorphic lesions are rare in syphilis. Even the lesions which the patient had on the legs, and which appeared to be circinate on a superficial examination, really turned out to be the result of the coalescence of diverse independent lesions.

Besides, the patient presents some slightly enlarged lymphatic glands in the groin and epitrochlea, but this enlargement was traceable to a reaction against the microbes of secondary infections of various open lesions.

The patient came from a region in which leishmaniosis prevails (Nazareth Railway).

We desired to make histological sections of the lesions, but we had to forego this because we had to be absent from the Capital of Bahia, to attend the Medical Congress of Sao Paulo, in which we were the representative of the Governor of Bahia, which made impossible to carry out the proposed histological study.

We have already had occasion to see a patient suffering from two diseases, boubas and leishmaniosis, in Santa Izabel Hospital, in Bahia; and in these cases in which the two diseases co-exist, the diagnosis is of extraordinary importance, inasmuch as the treatment of the two diseases is entirely different.

With these few brief and general considerations, we will now pass on to a clinical description of our patient.

Man. Fer. S., 32 years, of dark complexion, unmarried, native of Bahia, resident of Mutum (Jequiriza), entered the Saint Izabel Hospital in Bahia, in the infirmary of San Pedro, in August, 1916.

The patient's body looked as though it were covered with wounds and sores, and on that account he was admitted to the hospital. The patient's legs caused him the greatest amount of discomfort, for he feels great pains in them when he tries to go to sleep.

His disease began with a small swelling, accompanied by pain, on the posterior surface of the leg, at the juncture of the middle and lower thirds. This swelling increased, and, in time, presented a softened area in the middle, which opened spontaneously in June, 1916. This lesion remained open about eight months; the patient said that it disappeared



after he had taken some household remedies. The wound grew, with a very red base, and at first was smooth and very painful.

Whenever he walked, the contractions of the muscles made the leg pain very much, and caused hemorrhages, which bathed his leg in blood.

In February, 1916, other lesions had developed on the right leg, on the antero-external surface, in the neighborhood of the primitive lesions. At the same time, similar lesions appeared on the left leg, and a short time after another broke out at the angle of the mouth; a month later, another sore appeared on the upper lip, and so on over the whole body. In this same period, a lesion appeared over the styloid process of the ulna, which, when we saw it, had a major diameter of six centimeters and a minor of four centimeters. After he entered the hospital, various lesions appeared on the right hand at the base of the middle finger.

The patient emitted a bad odor on account of the large number of ulcerated lesions. The lesions were all monomorphous, multiple (248 in number), and evolving in a short time.

Previous illness: he had had gonorrhœa; venereal adenitis, which suppurated and opened spontaneously, leaving a persistent fistula, which healed later on; venereal sores (chancreoids) twice (eight sores the first time, three the second time); rheumatism (which seemed to have been gonorrhœal in character); measles; cataphora; smallpox; and malaria several times.

His parents are dead; his father died of smallpox; he does not know of what his mother died. He has a brother, of whom he has lost track. The patient affirms that, in the place where he lived, there are many persons with lesions similar to his own.

The numerous lesions were situated in different parts of the body, as we have already indicated: there were twenty-three lesions on the face, in varying stages of evolution; and more on the scalp, on the external occipital protuberance (inion). One on his right shoulder (deltoid region); one in left axilla; two on the right hand; two on the middle finger (one at the base of the phalanx, and the other on the phalanges); one in the space between the thumb and index-finger; one on the chest a little below the right nipple; three in the right gluteal region, and five in the left; ten on the anterior surface of the right thigh, chiefly located in the lower third; two on the scrotum (which caused a slight ganglionic reaction); four small ulcerations in the beginning, on the glans, penis and prepuce; six on the anterior surface of the left thigh, localized, as on the other thigh, in the lower third; eleven on the posterior surface of the right thigh, scattered all over this region; six on the posterior surface of the left thigh, also scattered; forty lesions were found on the posterior surface of the right leg, so that only a few small patches of undiseased skin remained; forty-one lesions were found scattered over the posterior surface of the left leg, but principally on the lower third; thirty-five lesions were found on the anterior surface of the right leg, situated along the border of the tibia, and principally at its middle third; forty-one were found on the anterior surface of the left leg, also localized as on the other leg; a small one on the dorsum of the right foot; one at the base of the fourth toe; one on the plantar surface of the big toe; and one in the interdigital space between the second and third toes.

In order to avoid counting the same lesion more than once, we marked with a dermatological pencil every lesion as it was counted.



In our patient, the disease, which was at first limited to the lower extremities, was spread all over his body by his fingernails, after scratching the lesions, and then inoculating healthy regions with his infected nails.

In this case we used protosan in our treatment. The protosan gave excellent results; with only a few injections (ten), many lesions had cicatrized. We could not continue the treatment in person, for we had to leave the city of Salvador, as already mentioned; and we left our patient in the skilful hands of our illustrious colleague, Dr. Genesio Salles, who gave only three more injections of protosan, whereupon the pains disappeared. Dr. Genesio Salles, after several days had passed, gave some intravenous injections of tartar emetic; but, unfortunately, about the middle of January, 1917, the patient contracted pneumonia, from which he died.

<i>Treatment</i> —Date:	October	2,	1916,	8 c. c.	of protosan
	“	6,	1916,	6 c. c.	“ “
	“	10,	1916,	6 c. c.	“ “
	“	16,	1916,	6 c. c.	“ “
	“	20,	1916,	4 c. c.	“ “
	“	25,	1916,	8 c. c.	“ “
	November	1,	1916,	8 c. c.	“ “
	“	8,	1916,	8 c. c.	“ “
	“	13,	1916,	8 c. c.	“ “
	“	17,	1916,	7 c. c.	“ “

In the early part of December, three injections of tartar emetic were given.

We made several complementary examinations. We found nothing abnormal in the urine; and all the internal organs performed their functions normally. In the feces, we found ova of anchylostoma, trichocephalus and ascarides. The differential blood count was as follows: polynuclear neutrophiles 59.6 per cent; polynuclear eosinophiles 8.41 per cent.; large lymphocytes 9 per cent.; large mononuclears 4.6 per cent.; small lymphocytes 17 per cent.; transition-forms 1.4 per cent. The neutrophile index of Arneth was represented thus:

I	II	III	IV	V
—	—	—	—	—
5	14	52	13	16

Quotient of deviation; 1.2

Arneth's formula in relation to the number of nuclei in 100 eosinophiles:

I	II	III	IV
—	—	—	—
3	58	53	6

These examinations were made by Dr. Bernardino Ramos, who, on that occasion, wrote a thesis on this subject.

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## BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Sect'y-Treas.

No doubt all members of the Louisiana State Medical Society, who had occasion to be present in New Orleans during the last annual meeting and that of the American Medical Association returned to their homes feeling fully repaid for the time spent attending the many Scientific and Social entertainments incident to the meetings.

From a "State Medical" standpoint the annual meeting of our Society, although devoid of scientific interest, proved a great success. We had a registration of 495 members of the Louisiana State Medical Society, and, from all records available, this goes beyond any registration at an annual meeting, in the history of our society.

The members of the Louisiana State Medical Society should extend a vote of thanks to the Orleans Parish Medical Society for the privilege of attending the many novel features which the society arranged for them and the guests of the American Medical Association. We will always look back upon this meeting as one of the glorious triumphs in the annals of our history. To be host for such a great organization as the American Medical Association is a distinct honor and the manner in which this was carried out to the satisfaction of a majority speaks for the master way in which the various committees handled each individual responsibility.

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We are very glad to report that the Committee on Public Policy and Legislation has been called upon to exert its influence during the recent meeting of the State Legislature. Dr. Clarence Pierson, of Jackson, La., is Chairman of this important committee and, during the session of this body, spent the greater part of his time

and energy keeping a watchful eye on medical legislation. There was some constructive work in the form of new bills which was sponsored by this committee but their chief energies were exerted in preventing legislation antagonistic to the ideals of our organization. The Executive Committee surrounded the Chairman with an able committee and supported him with funds.

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The Executive Committee of the Louisiana State Medical Society held a very important meeting, May 25th, with a very large attendance. At this time it was arranged for the next annual meeting of the Louisiana State Medical Society to be held April 19th, 20th, and 21st, 1921, in New Orleans, La.

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Some very important subject matters, relative to the Louisiana State Board of Medical Examiners, were taken up, recommendations made to the Governor, and prompt appointments made on the Board as result of this action. The promptness with which these appointments were secured is due, entirely, to the recognition of our Society by our energetic Governor, the Honorable Jno. M. Parker. Dr. Menville was appointed to succeed himself and Dr. Roy B. Harrison, of New Orleans, La., appointed to fill the vacancy occurred by Dr. J. A. Henderson.

The Executive Committee, after discussing at length several important phases of the Nursing Proposition which had been submitted to them by a committee which had been in special conference with the Louisiana Nurses' Board of Examiners, submitted to the Nurses' Board the following recommendations:

*First:* That the Nurses' Training day extend through eight hours instead of twelve as heretofore. *Second:* That the compensation for nurses in training be increased to not less than \$15, \$20 and \$25, respectively, for each year. *Third:* That the Nurses' Training Schools and Institutions adopt a more liberal policy with regard to charging the nurse for breakage, etc. *Fourth:* That the high standard required in training schools be maintained, but that the term of study be lessened one year. *Fifth:* That compulsory registration of nurses be enforced. *Sixth:* That Nurses' Training Schools and Institutions be required to give the under-graduate nurse a certain per cent of what money is paid by the patient to the institution, for private nursing, where an under-graduate nurse is on duty.

At the request of the American Medical Association the President of the Louisiana State Medical Society will very shortly appoint a Medical Health Committee to co-operate with our State Medical Education Board relative to health subjects pertinent to our State Schools of Education. This will be a very important committee and will be called upon to do some very valuable work. No doubt great good can and will be accomplished through such co-operation with our educational institutions. We have long felt the need of such a committee and I feel that it will be the source of satisfaction to all members of our state society to know that such work has begun. The personnel of this committee will be announced as soon as it is consistent.

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The Secretary-Treasurer wishes to announce that pursuant to his recommendations and endeavors made at the last annual meeting of the Louisiana State Medical Society, he has secured considerable encouragement for a Polyclinic course for the members of the State Society either previous or subsequent to the next annual meeting. The members will be acquainted, from time to time, as these plans progress. It is our earnest endeavor to arrange for some form of post-graduate work to be extended, FREE OF CHARGE, to any member of the Louisiana State Medical Society.

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Due to the fact that Orleans Parish Medical Society has sold its home, No. 141 Elk Place, I wish to announce that the temporary headquarters for the Louisiana State Medical Society are now similarly situated at No. 1551 Canal Street, the site of the Hutchinson Memorial, Tulane Medical College. Any communications should be sent to this new address.

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## NEWS AND COMMENT

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MEETING LOUISIANA STATE BOARD OF MEDICAL EXAMINERS.—The semi-annual meeting of the board was held in New Orleans June 10-12. The following members were present: President Dr. Leon J. Menville; vice-president, Dr. Thos. E. Wright; Dr. Roy B. Harrison, and Dr. E. W. Mahler, secretary-treasurer. Sixty-nine physicians passed the examinations and were granted certificates.



During the session the applications of nine physicians for reciprocity were approved and certificates granted them. Three midwives were granted certificates. The next examination meeting will be held in New Orleans, December 2-4, 1920.

LOUISIANA NURSES' BOARD OF EXAMINERS.—The semi-annual examination of the Louisiana Nurses' Board of Examiners was held in New Orleans and Shreveport, June 28, 29. Eighty-two applicants qualified as registered nurses.

TUBERCULOSIS RESEARCH FELLOWSHIP.—To encourage study of the means for the prevention and cure of tuberculosis, the Hennepin County Tuberculosis Association of Minneapolis, Minn., announces that it has set aside a fund for the support of a tuberculosis research fellowship in the Graduate School of the University of Minnesota. The candidate for the fellowship must be a graduate of a Class A medical college. The fellowship yields \$750 the first year and progressively increasing amounts for the second and third years as conditions warrant. Inquiries and requests for application blanks should be addressed to the Dean of the Graduate College, University of Minnesota, Minneapolis, Minn.

THE DEATH SQUAD.—A little band of seven Americans, who have faced the gravest danger day in and day out for six months fighting typhus in Esthonia, have had bestowed on them the name of Death Squad. Today only one of the original band, all members of the American Red Cross Commission to west Russia, remains on duty unscathed. Two are dead, three will bear to their graves the marks of the terrible spotted typhus which they contracted in the line of duty and one has left for America, to complete his studies for a medical degree.

AMERICAN SANITARY WORK IN THE VIRGIN ISLANDS.—A statement by the chief municipal physician of St. Thomas and St. John, Virgin Islands, for the first quarter of the present year shows that the death rate for the three months is the lowest on record, being about one-half the death rates recorded for the English, French and Dutch West Indian Islands and four below the 1919 rate of the registration area in the United States. In addition, the birth rate exceeded the death rate by over 133 per cent.; while infant mortality was 76.9, less than half the infant mortality recorded in the surrounding islands, and considerably below the rate in the states.

Health and sanitary work is under the supervision of the American naval government of the possession, and navy medical officers aver that the American Red Cross, which has in the last two years spent nearly \$44,000 for the equipment of hospitals on the island, has been of very great assistance in improving conditions. Although funds for the administration of the islands are limited, in two years the general death rate has been lowered from 39.5 per 1,000 to 13.6, and the infant mortality from 251.7 to 76.9.

**CIVIL SERVICE EXAMINATIONS.**—The United States Civil Commission announces open competitive examinations as follows: Associate in Clinical Psychiatry and Psychotherapy, August 24; Bacteriologist, Junior Bacteriologist, October 1; Medical Interne, St. Elizabeths Hospital, October 1. Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., the Secretary of the United States Civil Service Board, Customhouse, in their district. Applications should be filed with the Secretary of the Fourth Civil Service District, Old Land Building, Washington, D. C., for position as Associate in Clinical Psychiatry and Psychotherapy, and with the Civil Service Commission, Washington, D. C., for Bacteriologists and Medical Interne positions. Applications should also be filed without delay.

**TEACHING OF HOSPITAL ROUTINE.**—Owing to the difficulty in obtaining the services of trained hospital attendants and in order to improve this branch of the service Bird S. Coler, Commissioner of Public Welfare, New York City, several months ago established four training schools for hospital attendants. The schools are located at the City Neurological Hospital, Blackwell's Island; the New York Children's Hospital, Randall's Island; Sea View Hospital, Staten Island, and Greenpoint Hospital, Brooklyn. The pupils are being taught the principles of hospital treatment and how to care for simple and ordinary sick and chronic cases. They are the first schools of the kind to be established and should result in a better and higher type of hospital attendants.

**DONATIONS TO NEW YORK POST-GRADUATE SCHOOL.**—Two large gifts, one of \$25,000 from Ida C. Potts of Livingston, N. Y., and the other of \$20,000 from Mrs. E. B. Close, were recently added to the fund of which \$2,000,000 is the goal. Total subscription is now \$1,385,693.94.

ANOTHER SANITARIUM TAKEN OVER BY THE GOVERNMENT.—Belvedere Sanitarium of New Orleans, one of the finest of its kind in the United States was recently taken over by the United States Government.

THE ANNUAL MEETING of the American Laryngological, Rhinological and Otological Society was held in Boston, June 2-4. The following officers were elected for the ensuing year: President, Dr. Lee Wallace Dean, Iowa City; vice-presidents, Drs. Harmon Smith, New York; Joseph C. Beck, Chicago; Joseph B. Greene, Asheville, N. C.; William V. Mullen, Colorado Springs, Colo. and Hill Hastings, Los Angeles; secretary, William H. Haskin, New York and treasurer, Dr. Ewing W. Day, Pittsburgh.

RED CROSS EMERGENCY SURGICAL DRESSINGS PARCEL.—A standard emergency surgical dressings parcel, to be produced by Red Cross Chapters, and to be kept by them in quantities sufficient to meet readily whatever emergencies each chapter feels may be expected, has been adopted by the American Red Cross. It has been officially endorsed by the Surgeon General of the Army, the American College of Surgeons, the Surgical Section of the American Medical Association and the Conference Board of Physicians in Industrial practice. A manual of instructions for the preparation and production of the parcels has been issued to the chapters, and supplies will also be sent them.

APPEAL FROM PRESIDENT MEXICAN RED CROSS.—Responding to an appeal from Dr. Rafael Reyadas, president of the Mexican Red Cross, the American Red Cross has forwarded a shipment of anti-plague serum to aid in stamping out bubonic plague which since early in June has been making headway in Vera Cruz.

UNIVERSITIES AND COLLEGES RECEIVE GIFTS.—The Trustees of the General Education Board announce the following appropriations to medical schools in the United States: Washington University Medical School, St. Louis, for endowment, \$1,250,000; for additional laboratory facilities and equipment, \$70,000; Yale University Medical School, New Haven, Conn., \$1,000,000 toward a total of \$3,000,000 for endowment; Harvard Medical School, Boston, for improved facilities in obstetrics, \$300,000; for development of teaching in psychiatry, \$350,000; Johns Hopkins Medical School, \$40,000 toward a total of \$600,000, for development of a new department

of pathology. The Trustees of the Rockefeller Foundation have voted the following appropriations: Dalhousie University Medical School, Halifax, \$400,000 for buildings and equipment, and \$100,000 for endowment; Medical Research Foundation of Elizabeth, Queen of the Belgians, Brussels, 1,000,000 francs for medical research general purposes.

**NEW YORK CITY ACCEPTS STRAUS MILK LABORATORY.**—The Board of Estimate has accepted the recent offer of Nathan Straus to turn over to the city his milk pasteurization laboratory for the benefit of the children of the city, on condition that the city provide funds for carrying on and extending the work.

**NEW DEAN YALE SCHOOL OF MEDICINE.**—Dr. Milton C. Winternitz has been elected dean of Yale School of Medicine to succeed Dr. George Blumer, recently resigned. Dr. Winternitz is a graduate of Johns Hopkins University 1903 and became a member of Yale faculty in 1917.

**BOWDOIN MEDICAL SCHOOL'S ONE HUNDREDTH ANNIVERSARY.**—Bowdoin Medical School, Brunswick, Me., celebrated its one hundredth anniversary, which was observed by exercises held in the First Parish Congregational Church, on June 23.

**NEW YORK ASSOCIATION FOR MEDICAL EDUCATION.**—A meeting of this association was held on June 21, at which the work of the past year was approvingly reviewed and the following officers elected for the ensuing year: President, Dr. Haven Emerson; first vice-president, Dr. George David Stewart; second vice-president, Dr. Glentwood R. Butler; secretary, Dr. Otto V. Huffman; treasurer, Dr. Arthur F. Chace. Dr. Wendell C. Phillips, the retiring president, was extended a special vote of thanks for his valuable services as founder and organizer of the association.

**DERMATOLOGISTS ELECT NEW OFFICERS.**—The following officers were elected at the annual meeting of the American Dermatological Association: President, Dr. Jay F. Schamberg, Philadelphia; vice-president, Dr. Oliver S. Ormsby, Chicago; secretary-treasurer, Dr. Udo J. Wile, Ann Arbor, Mich.

**HONORARY DEGREES FOR MEDICAL MEN.**—The council of the University Senate in connection with the annual meeting of the British Medical Association in Cambridge has proposed the following



distinguished members of the medical profession for the degree of LL. D., *honoris causa*: Dr. Harvey Cushing, professor of surgery Harvard University; Dr. Simon Flexner, director of laboratories, Rockefeller Institute for Medical Research; the late Major-General William C. Gorgas, former president of the American Medical Association and Surgeon General of the U. S. Army; Sir T. Clifford Allbutt, K. C. B., regius professor of physics; Dr. Jules Bordet, president of the faculty of medicine and director of the Pasteur Institute, Brussels; Dr. A. Calmette, director of the Pasteur Institute, Lille; Dr. P. Giacosa, professor of materia medica and experimental pharmacology, University of Turin; Sir G. H. Makins, G. C. M. G., president of the Royal College of Surgeons of England; Sir Patrick Manson, G. C. M. G.; Sir Norman Moore, president of the Royal College of Physicians of London.

EUGENICS RESEARCH CONFERENCE.—The eighth annual meeting of the Eugenics Research Association was held at Cold Spring Harbor, Long Island, on June 25. Dr. Irving Fisher was elected president for the ensuing year. Plans were made for transforming the *Eugenical News*, an eight page monthly into a quartely *Journal of Eugenics*, to be under the auspices of the association.

MEDICAL MUSEUM CONGRESS.—The American and Canadian Section of the International Association of Medical Museums held their thirteenth annual meeting and exhibition April 1 and 2 at Cornell University Medical College, in conjunction with the meeting of the American Association of Pathologists and Bacteriologists. The following officers were elected for the ensuing year: President, Dr. W. M. L. Coplin, Philadelphia; secretary-treasurer, Maude E. Abbott, Montreal; assistant secretaries, L. Gross, Montreal and H. Goldblatt, Cleveland.

PERSONAL.—Dr. J. C. Abshire of Kaplan, La., for a number of years a member of the Louisiana State Board of Health has tendered his resignation. Ill health and lack of time were assigned as the causes of his resignation.

REMOVALS.—Dr. L. G. Poree, from New Orleans to Moneta, Cal. Dr. C. E. Alexander, from Lufkin, Tex. to Manning, Tex.

DIED.—On July 5, Dr. Philip Asher, of this city, aged 59 years, formerly Dean of the N. O. School of Pharmacy.

On July 10, Dr. E. A. Robin, of this city, aged 51 years, Pro-

fessor of Diseases of the Eye in the N. O. Polyclinic, Surgeon-in-charge of the Eye Department of the Senses Hospital, a leader in his chosen line and an able operator, also an esteemed collaborator of the JOURNAL.

On July 7, Dr. E. L. Henry, of Lecompte, La., aged 46 years, Ex-President of the Louisiana State Medical Society.

On July 5, Dr. C. J. McVea, of Baton Rouge, aged 51 years, a well-known practitioner and legislator.

On July 17, Dr. Domingo Bornio, of New Orleans, aged 60 years.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

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**A Laboratory Manual of Physiological Chemistry**, by Elbert W. Rockwood, M. D., Ph. D., Fourth Edition, Revised and Enlarged. F. A. Davis Company, Philadelphia.

The first portion of this book is devoted to carbohydrates, fats and proteins. One will find in these first pages careful experiments and descriptions of the newer accepted methods for sugar determination. Following is a clear discussion for fermentation and alimentary secretions. The methods given for gastric analyses are modern and excellent.

The Ionic theory is carefully explained and its importance in gastric analysis emphasized. The great clinical value of systematic blood chemistry is emphasized, and Rockwood has succeeded in making this subject clear, concise, and to the point. The methods of Folin and his co-workers are included, and the practitioner as well as the student of medicine cannot fail to be grateful to the author for bringing together the data on blood chemistry.

The relations of acidosis to body metabolism are taken up and the methods for determining alveolar CO<sub>2</sub> and plasma reserve are given.

The reviewer feels that Rockwood should have included the accepted methods for determining basal metabolism in his book.

The pages devoted to urine analysis are very complete and well arranged.

This little manual of Chemistry should find its way into the hands of every real physician and its place should not be with the vast majority of his other medical works, but it should be at all times on his laboratory table.

F. P. CHILLINGWORTH.

**Laboratory Manual of Pharmacology including Materia Medica, Pharmacopædics and Pharmacodynamics**, by A. D. Bush, B. Sc., M. D. A. F. Davis Company, Philadelphia.

Prof. Bush has included in his manual the three closely allied sub-

jects of *Materia Medica*, *Pharmacopædics* and *Pharmacodynamics* in the sequence named. He has tried to make the laboratory periods in *Materia Medica* interesting and has been fairly successful. The reviewer believes however that the success would have been greater if each drug was not taken up in alphabetical order.

In the section on *Pharmacology* some attempt has been made to group drug actions and the outlines for experimental work are well arranged and clear. Furthermore, the various forms of charts which Bush has devised for the tabulation of results obtained are excellent and will do much to fix drug actions in the minds of medical students.

The many drawings showing the paths of drug action will likewise result in a better understanding of *Pharmacology*.

This book can be recommended for the purpose for which it was intended, and it will also prove an aid to the physician reviewing his *Pharmacology*.  
F. P. CHILLINGWORTH.

**Common Diseases of the Skin, with Notes on Diagnosis and Treatment,** by G. Gordon Campbell, B. Sc., M. D., C. M. The Macmillan Company, New York.

This is an excellent presentation of a selected lot of skin diseases, commonly met. The illustrations are of the best and the text well written and thoroughly descriptive.

The author's especial judgment is displayed in the selection and arrangement of the photo cuts, which give variant types of each disorder presented. The book is altogether worth while. DYER.

**Syphilis. A Treatise,** by Henry H. Hazen, A. B., M. D. C. V. Mosby Co., St. Louis.

The mass of literature which has accumulated during the past fifteen years has needed compilation and digestion into some form, which may put it at the disposal of the profession. Hazen has done this, adding his practical skill in the presentation of the material. The introductory chapters on *Etiology* and on *Pathology* (partly written by Major M. A. Reasoner, U. S. A.) are complete and comprehensive. No less can be said of the rest of the book, in which each chapter carries its subject with ample and elucidating illustrations.

Regional syphilis is reviewed, including the internal organs, the vascular system and syphilis of the nervous system. Congenital syphilis finds full space.

The chapter on *Diagnosis* is especially noteworthy for its scope—from the laboratory point of view. The detail makes all methods clear for the reader. The *Wassermann*, its variants and congeners, as well as other serologic tests are given or are mentioned with brief notice. *Röntgen-ray* diagnosis is discussed with some excellent skiagraphs which are given, particularly as aiding in the recognition of bone syphilis.

The chapter on *Prognosis* emphasizes the fact that most victims of syphilis are not properly or adequately treated, either through their own neglect or that of the medical adviser.

The subject of *Prophylaxis* is especially interesting as given, because of the review of experience and method in the late war.

An excellent review of the various treatments by mercury is given with a preference for protiodid, if oral medication is practiced. The reviewer would state that after 30 years of experience with the mass of mercury (given in doses as high as twenty-four grains a day, in combi-

nation with iron) salivation has been rare, a conclusion different to that of the author.

The author does not overlook the more unusual drugs employed in syphilis, including "Zittman's concoction," so much in vogue in the last generation. Finally, the various arsenic preparations are discussed fully, with excellent detail on administration.

We join in the general conclusion that a patient who is Wassermann negative is not necessarily well forever, even though we are among those who believe that a case of syphilis taken early and well treated should get well.

Dr. Hazen has added to our resources in meeting syphilis and all who are privileged to read his book must be grateful. DYER.

**Education in War and Peace**, by Stewart Paton, M. D. Paul Hoeber, New York.

A collection of papers and addresses previously published or presented and now issued in book form. A philosophic study of reactions to the Great War, with suggestions as to the study of them. DYER.

**The American Illustrated Medical Dictionary**, by W. A. N. Dorland, A. M., M. D., F. A. C. S., Tenth Edition. W. B. Saunders & Company, Philadelphia and London.

Several hundred new terms are added in this edition, bringing a well known and valued desk companion up to date. DYER.

**Principles of Nursing**, by Charlotte A. Brown, R. N. Lea & Febiger, Philadelphia and New York.

A large fund of information, admirably presented in small space, at the same time covering practically everything a nurse should know—in fact, a nurse competent to know all the book contains and conveys should be qualified. The material is well arranged, with illustrations where needed. Particular phases, as of dietary, baths, and the like, are given place. A short chapter on microorganisms carries also the way to meet them. DYER.

**Hygiene and Public Health**, by George M. Price, M. D., 2nd Edition. Lea and Febiger, Philadelphia and New York.

A compendium on the subject in which all material is classified and presented briefly under each head. The chapter on the Control of Communicable Diseases is especially interesting as it gives each disease in a tabular way, bringing out the salient features of each. A handy book for ready reference or brief review. DYER.

**Disease of Nutrition and Infant Feeding**, by John Lovett Morse, A. M., M. D., and Fritz B. Talbot, A. B., M. D. The Macmillan Company, New York, 1920.

In the second edition of their most valuable book the authors have brought the subject up to the present time. The book was originally written to suit the demands of the students who wish to become acquainted with the basis of infant feeding and of the general practitioners who wished to learn the clinical and practical sides of the subject.

The book has undoubtedly served the purpose for which it was in-



tended, and in the second edition the authors have added to the various subjects the results of the investigations carried on during the period which intervened between the appearance of the first and second editions. Two chapters have been added to the text, one upon Spasmophilia and one upon Acidosis. These subjects have been thoroughly reviewed and are not only in a presentable but a digestible form.

The book should be in the library of every medical man as it is especially good as a reference work.

L. R. DeBUYS.

**A Text Book of Dermatology**, by Dr. J. Darier. Authorized Translation from the Second French Edition. Edited with notes by S. Pollitzer, M. D. Lea and Febiger, New York.

The work of Darier in the field of dermatology has been known to specialists in this field for many years and the contributions from this worker have materially raised the standards in the laboratory and the clinical study of skin diseases.

It is with considerable gratification that the reviewer presents this notice of an English translation of Darier's text, in which translation the American editor has followed faithfully the original work. To Dr. Pollitzer large credit has to be given for the excellent translation and for the excellent manner in which he has presented Darier to the English speaking public.

As for the book itself: first of all, it is different from our usual American text in that the eminent French dermatologist at once presents his diseases without the usual preliminary introductory chapters on the fundamental study of the skin itself, which, after all, has a doubtful place in such texts. The individual articles or subjects discussed reflect the viewpoint of the French school in their practical presentation. There is no attempt at exhaustive analysis of any disease, yet there is a comprehensive discussion of each disease presented in sufficient space to satisfy the student of skin diseases.

As a text book this translation in English of a French work will find place while it will interest those who are students of skin diseases in the French point of view. There is no attempt at making this work either an academic or an exhaustive work on skin diseases. It will serve, therefore, as a good practical text.

An appendix carries about thirty pages of therapeutic suggestions, all of which should prove of service.

DYER.

**The Don Quixote of Psychiatry**, by Victor Robinson, Ph. C., M. D. Historico-Medical Press. New York.

It is worth while stepping aside from the every day routine to read of the career of a man who has served his time for his fellow men, particularly when the memoir is written so entertainingly. Not only does the volume give you an excellent biography of Dr. S. V. Clevenger, but incidently it contains much of information and commentary regarding his contemporaries,—most of them well known in advanced medicine of the last three decades.

The biographer has touched the higher lights as well as the low in Clevenger's life and the book is an excellent review of the reform in the care of the insane, that is, in so far as the experience of Dr. Clevenger helped to illuminate the evils of the old system. Life at best is prosaic to most men and to most doctors, and it is keenly exhilarating

to read of one who throughout followed the road which led him into the problems of life. DYER.

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This edition written since the war contains a description of all methods introduced during the conflict for the treatment of wounds, injuries and surgical diseases which the civilian surgeon may be called on to treat, but such conditions as gas poisoning, trench feet, etc., which are not likely to prove of practical value to the civil surgeon have been omitted.

The increase in the size of the book is largely given to the discussion of the treatment of infected wounds, fractures of the shafts of the long bones and in repairing the defects of war wounds, including a large number of new illustrations.

The entire volume has been well revised with many additions, is well written and arranged with an excellent index and quite in keeping with the previous editions. ALLEN.

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Quinine Metrorrhagia, by Albert J. Chalmers, M. D., F. R. C. S., D. P. H. and Major R. G. Archibald, D. S. O., M. D., R. A. M. C.

Some Soudanese Diphtheroids, by Albert J. Chalmers, M. D., F. R. C. S., D. P. H. and Norman Macdonald.

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## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for June, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	1	1	2
Intermittent Fever (Malarial Cachexia)			
Smallpox	2	8	10
Measles			
Scarlet Fever			
Whooping Cough	4		4
Diphtheria and Croup			
Influenza	1		1
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	36	33	71
Cancer	27	15	42
Rheumatism and Gout		2	2
Diabetes	1	3	4
Alcoholism			
Encephalitis and Meningitis	1	2	3
Locomotor Ataxia	3		3
Congestion, Hemorrhage and Softening of Brain	10	4	14
Paralysis		7	7
Convulsions of Infancy	1	1	2
Other Diseases of Infancy	7	10	17
Tetanus		1	1
Other Nervous Diseases	1	1	2
Heart Diseases	46	26	72
Bronchitis	1	4	5
Pneumonia and Broncho-Pneumonia	11	12	23
Other Respiratory Diseases	2	2	4
Ulcer of Stomach	3	1	4
Other Diseases of the Stomach	3	1	4
Diarrhea, Dysentery and Enteritis	29	16	45
Hernia, Intestinal Obstruction	3	2	5
Cirrhosis of Liver	5		5
Other Diseases of the Liver	1		1
Simple Peritonitis			
Appendicitis	7	1	8
Bright's Disease	21	12	33
Other Genito-Urinary Diseases	9	10	19
Puerperal Diseases	6	6	12
Senile Debility	2	1	3
Suicide	4		4
Injuries	21	16	37
All Other Causes	21	23	44
<b>TOTAL</b>	<b>290</b>	<b>223</b>	<b>469</b>

Still-born Children—White, 18; colored, 18; total, 36.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 12.00; colored, 24.32; total, 15.39. Non-residents excluded, 13.08.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmosphere pressure	30
Mean temperature	81
Total precipitation	8.45 inches
Prevailing direction of wind, southeast.	



# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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## EDITORIAL

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### THE PRACTICE OF MEDICINE TODAY.

A student of the statistics of the medical practitioners of this country not many years ago figured that forty per cent. of all graduates in medicine abandoned their calling after five years' experience in it. Under these statistics, the average income of the doctor in the United States was one hundred dollars a month. With the higher standards for entrance and for advancement in medical schools, the number of graduates has been reduced about one-half since the time when those statistics were presented. The status of the medical man in the United States has improved materially, as a result.

Educators themselves are not yet sure of the best way to train men to enter the field of medicine and a variety of experiments has been and is being conducted with the idea of stabilizing medical education.

Better trained students make better doctors and the requirement

of a college education before the study of medicine begins has brought to the medical schools more earnest and more intelligent students.

The fact stands out that the purpose of a medical school is to train men to practice medicine. No means should be spared to afford the student every opportunity of acquiring modern scientific methods, in diagnosis and in the treatment of disease; but it is not the function of the medical school to require of every student so high a scientific training as to render him useless in the final test of the physician at the bedside.

In an analysis of the graduates from one of the leading medical schools in this country, over a period of five years, the rather interesting fact was presented that only four per cent of the output was located in small towns or in country districts; ninety-six per cent had gravitated to the larger cities.

The plea comes repeatedly for the consideration of two classes or sorts of medical graduates, one to meet the demands for the country practitioner and the other to meet the standards which seem to necessitate, as the finished type, the ultra-trained in diagnosis and in particular fields of practice. No such separation of classes can occur, with the modern conception of a medical education, but the discussion points to the need of a better training for the student in the practical side of medicine, so that he may, when graduated, meet the needs for the general practitioner. The solution is partly on the way in the establishment of higher grade graduate schools. Here research departments, with provisions for special training in the more advanced branches, promises better trained specialists.

The experience at the Officers' Training Camps of the Army in determining the fitness of thousands of self-styled specialists showed how lamentable conditions were among men who, after a few months in a metropolitan clinic, had returned to their homes as specialists and then permitted the indulgent public to suffer through their mutual ignorance.

Within the past ten years the whole structure of medical education in the United States has been recast and today there is too much tendency to standardize upon a basis of a stereotyped theory, not based upon practical experience.

The science of medicine has consistently travelled faster than the art of medicine. It may soon be evident that the art of medicine will have been left so far behind that its place may be overlooked.

This must prove unfortunate, for the sole purpose of medicine, in or out of the medical school, is the prevention and the cure of disease. Modern society, in its rapid phases of developing civilization, brings newer diseases, or more variant types of older diseases and the general problem for the physician does not materially change, for there can be no time when all diseases may be absolutely prevented.

The division of medical effort in medical organization is certain to come about; it is already on the way. Philanthropic bodies, among which the Rockefeller International Health Board stands in stellar place, already are engaging the attention of medical schools in training men for health salvage and disease prevention, and the output has not yet kept up with the demand for such men. State Health Boards and the envisaged Department of Public Health in the Federal Government will more and more demand specially trained graduates in medicine, particularly selected for work in preventive medicine. The differentiation of a considerable percentage of graduates into special fields of practice will further diminish the rank and file of the much needed general practitioner who must care for the every day sick—but these must be better qualified than ever to take care of the bulk of the public who will always need the doctor.

The economics of supply and demand and the related question of adequate compensation for services must yet be solved. Just now it is an individual equation, based usually upon the physician's own statement of the value of the service he renders and upon the ability of the patient to pay. Even at best, the pay is not commensurate, when the intelligence and responsibility of services are weighed. No other profession is as lavish of its service, nor so considerate in its demands on those who should pay. The compensation for proletarian service must soon be assumed by the state, which must also soon solve the matter of adequate medical care of the smaller communities.

The Health Insurance plan of Great Britain offers a basis for contemplation—but this country must consider a broader plan, which will care for the wages of those physicians who may be willing to serve the state in the care and cure of the sick, as well as in preventing disease. The state assumes to regulate the practice of medicine, determining licensure and the obligations of the doctor to the state in the reporting of certain diseases, but the state as yet does not

compensate for the service. Hospitals are no longer the refuge of the pauper only; more and more they are becoming the place of choice for those who are sick and who need care and where municipalities exercise any provision at all, they are taking into consideration the future demand for community care, of those who are willing and able to pay.

These are problems in State Medicine, which are paramount today and which merit thoughtful reflection and consideration for future action.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### UTERINE FIBROIDS COMPLICATING PREGNANCY.

By AIMÉ PAUL HEINECK, M. D., Chicago, Illinois.

During pregnancy, women are subject to many pathological conditions that influence gestation, parturition, and sexual life. When of a surgical nature, such conditions find in pregnancy no contraindication to the application of surgical principles, e. g., appendicitis being met by appendectomy; cholecystitis and cholelithiasis by cholecystotomy or cholecystectomy, either being considered routine performance.

There arises, however, in the course of pregnancy a condition to which obstetricians, gynecologists and surgeons have given an entirely inadequate amount of study, namely, the occurrence of uterine fibroids.

Uterine fibroids afflict all races. They originate during menstrual life and are more frequent than ordinarily suspected. When they occur in pregnancy, two lives are at stake; therefore, the subject is well worth being brought to the special attention of the medical profession.

The opinions expressed in this paper are based on my personal experience supplemented and controlled by an analytical survey of 380 cases reported with adequate data in which the diagnosis received either operative or post-mortem confirmation. The following observations offer themselves:

Any part of the uterus may be the seat of a fibroid; even the entire uterus may undergo myomatous degeneration.

Uterine fibroids are found associated with any form of pregnancy and occur in gravid uteri, otherwise normal or abnormal, congenitally so or acquired.

Uterine fibro-myomata exert an unfavorable influence upon conception, gestation, labor, and the puerperium.

Uterine fibroids originate and may continue during all periods of

menstrual life, may first become manifest in primiparæ, deutiparæ, and multiparæ as is evidenced by the following table:

Primiparæ.....	101
Deutiparæ.....	30
III-paræ.....	12
IV-paræ.....	8
V-paræ.....	7
VI-paræ.....	6
VII-paræ.....	3
VIII-paræ.....	3
IX-paræ.....	1
XI-paræ.....	1
XIV.....	1
Not Stated.....	207

The youngest patient was 19 years old; the oldest three each, 45 years old.

19 to 24 years inclusive.....	17
25 to 29 years inclusive.....	54
30 to 34 years inclusive.....	84
35 to 39 years inclusive.....	76
40 to 44 years inclusive.....	37

Fibroids vary in number, location, size, anatomical relation, and also in shape, consistency, structure, mode of implantation, and rate of growth.

The uterus has been found to be the seat of fibroids originating in the cervix, in the body, or in both body and cervix. 154 of the cases under consideration presented one fibroid; 22 cases, two fibroids; and 56 cases several fibroids.

Cervical fibroids are of rarer occurrence than those of the corpus. Among the cases herein considered, one notes 25 of the former to 129 of the latter. The cervical variety arises from any part of the cervix; may or may not invade the cervical canal; and frequently burrows under the peritoneum on the anterior or posterior aspect of the uterus. Submucous cervical fibroids not uncommonly prolapse into the vagina. Of the corpus fibroids, 12 originated in the cornu, 39 in the fundus, 44 in the anterior wall; and 44 in the posterior wall; in 8 cases, they occupied several parts of the body.

A classification serviceable alike from an anatomic, diagnostic and therapeutic viewpoint, is based on the relation of the tumor to the various layers of the uterine wall. Thus fibroids are designated subperitoneal, interstitial or intra-mural, and submucous. The subserous and submucous types are sessile or pedicled. In many cases, more than one uterine layer is involved, and in a few, the whole uterus appears to have undergone fibro-myomatous degeneration.

The following table indicates their reported distribution:

	Cervix	Body
Subperitoneal .....	2	66
Interstitial .....	29	74
Submucous .....	8	29

Pedicles vary in thickness and length, and at times undergo torsion. The latter is a rare accident; few pedunculated fibroids having a pedicle long enough to allow of rotation.

Uterine fibroids by virtue of their weight, volume, or location displace and fix the pregnant uterus forward, laterally, upward, downward or backward, causing pathological versions and flexions, and even pelvic impaction and incarceration. Such displacements are temporary in the beginning, but become permanent when inflammatory adhesion of the tumor to neighboring structures or organs takes place. Retro-uterine fibroids adherent to the pelvic floor will often be found as immovable as intraligamentous tumors.

When pregnancy develops in a myomatous uterus, the nutrition of the fibroids is unfavorably influenced by the altered conditions and hypertrophy of the tumor results. The hypertrophy of the tumor is an effect of the increased vascularity and of the increase in number and size of the tumor cells. The softening being largely due to edematous infiltration of the neoplasm, allows changes in the shape of the tumor such as flattening against the uterus, against the pelvic walls, etc.

Fibroids like other tissue masses are subject to inflammatory and degenerative changes. These changes occur previous to, or after abortion, or premature labor; previous to or after full-term labor. Owing to their low vitality, fibroids offer little resistance to invading germs, either implanted upon, or conveyed to them from the uterine cavity, or elsewhere,<sup>10</sup> by way of the lymphatic or blood-vessels. Inflammation of a fibroid terminates in gangrene, partial or complete, central or peripheral; in suppuration,<sup>5</sup> or in the formation of adhesions. Adhesions of inflammatory origin by displacing and fixing the gravid uterus interfere with its functions and that of contiguous viscera, and are an important factor in the etiology of dystocia. Adhesive inflammation may bind the tumor to one or more organs<sup>41</sup> and structures,<sup>9 12 19 24</sup> intestines,<sup>39</sup> Douglas' Pouch,<sup>38 42</sup> and to the abdominal wall.<sup>41</sup>

Gangrene is due to different factors: circulatory and nutritive disturbances, pressure within or outside of the uterus, lessened leucocytic defense and ease of infection of neoplastic tissue.

Fibroids are subject to calcification, to fatty, cystic, myxomatous, or red degeneration. Degeneration occurring in the interior of the fibroids can lead to grave peripheral complications. Red degeneration of fibroids is an aseptic necrobiotic process characterized by hemolysis and autolysis of tissues. The tissue of the fibroid becomes necrotic and refuses to stain, and presents on section a raw-meat, brown or mahogany color which darkens on exposure to the air. The color is due to laking of blood in the necrosed tissue and diffusion of blood pigment into the cells. Red degeneration occasionally met in non-gravid myomatous uteri, is more frequent, more intensive in uterine fibroids co-existing with or complicating pregnancy. In over fifteen cases herein considered, one or more of the fibroids had undergone red degeneration.<sup>14 20 4</sup>

The process of red necrosis may advance to complete liquefaction of tumor with rupture of either into the peritoneal or uterine cavity, and secondary infection. In four cases, distinct evidence of cystic degeneration was present; the cyst wall being formed by the capsule and the periphery of the tumor; the cyst contents, by a chocolate colored fluid.<sup>28</sup>

Pathologic conditions co-existing with uterine fibroids are either purely co-incidental or determined partly or wholly by the neoplasm. The frequent association of uterine fibroids with localized peritonitis<sup>32</sup> and with disease of the uterine appendages is too well known to call for more than passing mention.

Purely co-incidental pathological conditions are recorded: appendicitis, ovarian cyst, torsion of the pedicle of a dermoid ovarian cyst, intraligamental echinococcus cyst, carcinoma of the cervix, etc.

Without repeated examination, the diagnosis of uterine fibroids and co-existing pregnancy is difficult to establish. The signs of pregnancy may be mimicked by fibroids and vice versa; e. g., uterine souffle, bluish discoloration of the vaginal wall, Braxton-Hicks, intermittent uterine contractions; ballottement and abdominal palpation often give analogous findings in pregnancy and uterine fibroids.

Pressure upon the vascular channels is provocative of an oedema involving the legs; upon the nerves of the sacral plexus, of pain; upon the intestines, of intestinal obstruction; upon the rectum, of rectal tenesmus, constipation and diarrhea. Pressure upon the kidneys and ureters, anuria and uremia. Pressure upon the



bladder is followed by vesical tenesmus, frequent, painful and difficult micturition, and in some cases, by retention of urine.

Inflammation and degeneration occurring in fibroids determine local and constitutional symptoms. All degenerations, all acute inflammations of fibroids give rise to pain,<sup>18</sup> varying in duration and intensity according to the extent, acuity, and nature of the pathological process. The pain may be severe enough to necessitate the use of opiates.<sup>29</sup> Closely associated with pain is tenderness. During pregnancy, degeneration should be suspected whenever a uterine fibroid becomes tender and painful. The fever, pain, and tenderness present in uterine fibroids are provoked by one or the association of two or more of the following factors:

1. Rapid and sudden increase in size of tumor, as in edematous infiltration.<sup>34</sup>
2. Serious mechanical pressure exerted by the new growth upon the rectum, bladder, and ureter.
3. Pelvic impaction and incarceration of tumor.
4. Bacterial inflammation of myoma or myomata, phlegmonous, suppurative or gangrenous in type.
5. Degeneration of tumor, cystic, red, etc.
6. Torsion of tumor's pedicle.
7. Torsion of tumor's pregnant myomatous uterus on its long axis.
8. Peritonitis, localized or diffuse.
9. Simultaneous adnexal disease, with or without peritonitis.
10. Impending abortion or premature labor.

A fibroid is a deformity, and if bulky may cause bulging and asymmetry of one or more abdominal regions. Abdominal and vagino-abdominal palpation enable us to obtain suggestive or fairly accurate information relative to the size, shape, consistency, mobility, and anatomical relations of uterine fibroids. A co-existing pregnancy makes the interpretation of the palpatory finding more difficult.

Uterine fibroids influence fertility even before they produce subjective symptoms, to what extent is not as yet fully determined. In married myomatous patients, sterility is more common and fertility rarer than in married women of a corresponding age with normal uteri. Fibroids may so displace the cervix that it is not bathed in seminal fluid during the sexual act; they may obstruct

the uterine cavity and compress the interstitial portion of the tube. Small subserous myomata do not diminish the capacity to conceive. In a general way, the chances of conception diminish in proportion to the size of the tumors and to their influence upon the uterine mucosa. Submucous fibroids determine the greatest endometritic disturbances:—atrophy, changes in the uterine glands, inflammation, etc., and therefore, of all fibroids, they are the most frequently associated with sterility.

A woman is more liable to conceive after the successful removal of fibroid or fibroids. Women having uterine fibroids conceive less often and frequently their first gestation occurs at a later period of life than in women with normal uteri. There may be an interval of many years between the pregnancies in fibro-myomatous uteri; from three to seventeen years in the cases we analyzed.

During its entire course, uterine fibroids are a grave menace to pregnancy. They frequently cause abortion, premature labor, or death of fetus with retention of ovum in utero. A placenta partly implanted upon a submucous or an interstitial fibroid does not develop normally.<sup>13</sup> Placenta accreta, partial detachment of the ovum, etc., may result. If the chorionic villi become imbedded upon a part of the mucosa covering a fibroid, the placental development and incomplete nutritive changes resulting therefrom is abnormal: the ovum may atrophy and the fetus die. "The seed has not fallen on good ground."

All uterine displacements, retroversion, retroflexion, prolapse, etc. and all uterine tumors predispose to abortion and premature labor. Pelvic incarceration, pelvic impaction, inflammatory adhesion of the fibroid or fibroids to pelvic structures impede the enlargement and ascent of the pregnant uterus. Important in the causation of abortion are the inflammatory and degenerative changes to which neoplasms are subject. It goes without saying that the cause of sterility and of abortion that obtain in women with normal uteri are equally operative in myomatous women.

The hemorrhages accompanying uterine fibroids bear no fixed relation in amount, duration or frequency to the size of the tumor; they always interfere with the growth of the ovum. A hemorrhage may be insufficient to detach the ovum, and yet cause marked disturbance in the utero-placental circulation. Abortion attended by hemorrhage, more or less severe, may be caused by a pedicled submucous fibroid insinuating itself into the cervical canal.

“When a woman with a uterine fibroid conceives, it is certain that her life is in jeopardy, and not only as long as the fetus remains within, but also when it is expelled, whether it occurs prematurely or at term.”<sup>24</sup> The danger to the child’s life is proportionate to the nature of the obstruction, duration of labor, and method of delivery. Fibroids cervical or corporeal, intensify the discomforts of pregnancy to such a degree that at times operative relief becomes imperative. According to Scipiades, in the myomatous cases that go to term, the first stage of labor is prolonged, the second very painful, and the third more abnormal in 21% of the cases. Fibroids retard and arrest the expulsion of a living or dead child through the natural passages, and not uncommonly demand the employment of radical means of delivery. Delivery per vias naturales in certain cases of retro-uterine or retro-cervical tumors is impossible. A large tumor may so deviate the uterine axis that the presenting part does not enter the pelvic brim, and an abnormal fetal presentation results. The presence of one, two, or more tumors and the resulting poor accommodation of the fetus to the maternal passages not infrequently cause faulty or vicious fetal presentation: shoulder,<sup>6</sup> left sacro-anterior,<sup>3</sup> foot,<sup>17</sup> breech,<sup>30</sup> transverse.<sup>40</sup> Fibroids by their volume,<sup>17</sup> and their location may obstruct the maternal passages, prove a bar to normal labor,<sup>23 13 32</sup> and necessitate suprapubic delivery to save the life of either the child or mother or both.

A low-down cervical tumor may prevent dilatation. Blocked labor if unrelieved may result in the rupture of the uterus. Uterine fibroids interfere with and weaken uterine contractions;<sup>1 27</sup> not uncommonly, they cause uterine inertia,<sup>22</sup> and thereby prolong labor. Intra-mural myomata occupying a great part of the uterine wall, may prevent uterine contraction and retraction. Uterine inertia, impaired uterine contractility and retractility, pathologically adherent placenta, tortuosity of the cervical canal, make retention of placental tissue and post-partum hemorrhages common in myomatous uteri.

Placenta previa and adherent placenta are unusually frequent in pregnancy associated with uterine fibroids. Changes in the uterine mucosa incident to the presence of fibroids and insertion of the ovum upon the tumor often cause the placenta to be abnormally adherent. The pathological adhesions interfere with the spontaneous expulsion of the afterbirth and may necessitate manual<sup>21 25</sup> or instrumental separation of the placenta.<sup>43</sup> In fibroids complicating pregnancy,

the post-partum and puerperal hemorrhages may be abundant, even fatal.<sup>16</sup> It is not due to retained placental tissue; it may be due to atony of the uterus, or to the fibroid itself.

During the puerperium, fibroids delay involution, predispose to thrombo-phlebitis, obstruct the lochial flow, and often become infected and necrotic from injury incident to delivery. Purely obstetrical assistance as forced delivery or extraction past the tumor entails the danger incident to contusion or embolism. Immediately after delivery, there ensue in uterine fibroids, circulatory and degenerative changes predisposing to infection. The frequent infections of submucous fibroids is due partly to their location and partly to the bruising of their pedicle by the child's passage through the parturient canal.

The spontaneous expulsion of submucous fibroids into the vagina is accompanied by free bleeding and has been mistaken for a miscarriage. It is observed chiefly at labor and during the puerperium, in connection with small-based submucous fibroids.

#### TREATMENT.

In uterine fibroids complicating pregnancy, that treatment is most successful which best fulfils the following three conditions:

1. The delivery of a living and viable child.
2. The complete removal of all fibro-myomatous tissues.
3. The restoration of the mother to sexual and anatomical integrity.

Expectant treatment has dangers, viz., postponement of the climacteric to fifty odd years, formation of submucous nodules, causing repeated hemorrhages, cardiac degeneration, thrombosis and embolism, and malignant degeneration of tumor tissue. It is unsurgical to abandon the patient to the uncertain, though at times favorable influence of the menopause on the course of fibroids. Fibroid tumors of the uterus are a surgical disease, and like neoplasms in other organs are amenable only to operative removal. Surgery eliminates the danger of sepsis, be it puerperal or other following degenerating, bruised, or infected myomata and averts many complications resulting directly or indirectly from fibroids.

The tolerance of the gravid uterus to operative procedure is known. When a uterine fibroid gives rise to symptoms that lead to detection, there is considerable likelihood that the underlying disturbances will endanger the patient's health and life. It being agreed that operative treatment is called for in fibroid complicating



pregnancy, the next thing to determine is when to operate. Early operation allows conservative procedures where delay may entail the sacrifice of the uterus. At the end of pregnancy, a woman is in an unfavorable state of health for a major operation. Operative intervention is imperatively indicated in the presence of the following:

1. Bad general condition of mother. Often myomatous patients are first seen in a deplorable general condition, the result of hemorrhage, accompanying disease of the endometrium, adnexa, or peritoneum, conjointly or separately.
2. Intolerable pain.<sup>34 41 38</sup>
3. Inability to work.
4. Dyspnea due to size of tumor.
5. Rapid growth of tumor.<sup>38</sup>
6. Extreme abdominal distention.
7. Renal insufficiency.
8. Pelvic incarceration or pelvic impaction of tumor.
9. Repeated and profuse hemorrhages.
10. Torsion of tumor's pedicle.
11. Rotation of the uterus on its long axis.
12. Gangrene of tumor, partial or complete, central or peripheral.
13. Tumor degeneration, cystic, red, etc.
14. Septic complications.
15. Severe pressure on neighboring organs, ureter, bladder, rectum, etc.
16. Size and multiplicity of fibroids impeding the normal progress of pregnancy.
17. Fibroids that are a hindrance to birth through the normal channels (in these cases, forceps and version are contra-indicated.)
18. Fibroids in the body of the uterus interfering with the uterine contractions.
19. Fibroids interfering with the outflow of the lochia.
20. Fibroids springing from the back of the lower segment of the uterus.

The following operative procedures have been advised:

1. Induction of abortion or premature labor.
2. Myomectomy.
  - (a) Vaginal:
    - (1) By morcellement.<sup>44</sup>
    - (2) Pedicle ligated and tumor removed.

- (b) Abdominal: (1) Tumor freed from surrounding organs and pedicle ligated.
- (2) Enucleation.
3. Cesarean Section.
- (1) Not immediately preceded or followed by any other operative act.
- (2) With myomectomy.
- (3) With hysterectomy.
4. Hysterectomy.
- (a) Vaginal.
- (a) Less disturbing to the statics of the pubic organs.
- (b) Abdominal.
- (1) Supra-vaginal. (b) Of easier and more rapid execution.
- (c) Lower morbidity and mortality.
- (2) Total. (a) If cervix is myomatous or otherwise diseased.
- (b) If there are any suspicions of malignancy.

#### ABORTION.

Abortion accidental or induced exerts no curative influence on the treatment of uterine myomata. It is an illogical operation as it sacrifices the product of conception and in no wise protects the mother from the perils of fibroids. There are dangers incident to abortion:

1. Hemorrhage from myomatous uteri is at times alarmingly profuse and difficult to control.
2. Retention of the decidua and impeded escape of blood and lochia are caused by the displacement of the cervix and the distortion of the uterus.
3. Retained placenta can be due to various factors: the existing tortuosity of the cervical canal, defective uterine contractility and retractility, pathologically adherent placenta, etc.

4. Susceptibility to post-abortive sepsis is increased in cases of this nature.
5. Subinvolution is engendered by the presence of fibro-myomata in the uterine wall.

#### MYOMECTOMY.

Myomectomy has been successfully performed on gravid uteri at all periods of gestation and pregnancy has continued uninterrupted; has also been done at time of labor and during the puerperium. There are two objections to myomectomy, (1) it does not prevent recurrences; (2) it carries with it the possibility of uterine rupture in future gestations.

For the performance of myomectomy, the operator has the choice of two routes, vaginal and abdominal. The vaginal route has a limited field of usefulness. It is the operation of election.

1. In cervical fibroids,<sup>45</sup> interstitial or pedicled;<sup>20</sup> the latter are easier of access.
2. In long-pedicled submucous fibroids of the body protruding through the cervical canal.
3. In fibroid polypi causing lochiometra.

In a word in all cases of cervical fibroids pedunculated or sessile so situated that their vascular supply can be completely controlled by the operator.

The vaginal route is contra-indicated in the presence of:

1. Disease of the uterine adnexa.
2. Intestinal adhesions to the myoma.
3. Of malignant changes in the tumor.
4. Of myomata that can be drawn into the vagina.

For myomectomy as well as for Cesarean Section and Hysterectomy, the abdominal route is preferable because:

1. It gives the operator a clear view of the operative field.
2. Allows separation of adhesions.
3. It gives full control of bleeding points.
4. It furnishes better access to tumor or tumors.
5. It enables the operator to adapt the operative procedure to the case in hand.
6. It facilitates the correction of any associated abdominal pathological condition.<sup>26</sup>

(Grad in his case shelled out three fibroids and removed an ovarian cyst. Eight months later, normal delivery.)

Myomectomy vaginal or abdominal is a conservative non-mutilat-

ing operation. Though presenting difficulties in interstitial and intraligamentary tumors, it is as a rule of easy and rapid execution, presenting few hemostatic difficulties. When feasible, it is the ideal operation for uterine fibroids. The operator must not disregard the pathological fact that a small nodule left behind may grow to a large tumor before the end of pregnancy.<sup>7</sup> Myomectomy is preferred to hysterectomy, abdominal or vaginal, total or supra-vaginal, because:

1. In the sterile woman, the uterus being left intact, conception may follow. Though pregnancies after myomectomies are not frequent, nevertheless, the hope of pregnancy is not illusory.
2. In the pregnant woman, it removes the disturbing symptoms and cures the condition. Especially are conservative measures indicated in women below 40 years of age whose uteri are not studded with fibroids and who are willing to face the probability of a second operation.
3. It gives gestation the opportunity to continue. After myomectomies, give opium to prevent abortion.
4. It permits the delivery of the child through natural passages.
5. The post-operative shock is milder, the convalescence shorter (especially after vaginal myomectomy) and the mortality rate for both mother and child is lower.
6. The menstrual and generative functions of the mother are retained. "Unable to push the tumor out of the pelvic brim, etc."<sup>37</sup>
7. If after the initial incision, myomectomy is found unsafe or impossible because tumor is too large, too adherent or too deeply imbedded, no harm has been done and the appropriate operative act may still be performed.

#### CESAREAN SECTION.

As pregnancy approaches its completion, the delivery of a living child becomes a new factor. In gravid myomatous uteri, Cesarean Section is indicated near or at term in all cases in which delivery through the natural passages:

1. Would contuse the tumor, thereby predisposing it to infection and degeneration.
2. Would be extremely difficult as in the presence of large and multiple fibroids interfering with uterine contractions.
3. Would be mechanically impossible.



4. Would inflict serious traumatism upon the maternal tissue or endanger the mother's life or future well-being.
5. Would jeopardize the life or health of the child.

To combat one or more of the aforementioned anomalies, sixty-five Cesarean Sections were performed; they yielded fifty-nine live babies in fifty-five single, and three twin pregnancies. In the course of a Cesarean Section on a myomatous uterus, myomectomy, if feasible, is indicated.

Fibroids are a dangerous element in an involuting uterus. The benefits resulting from their removal far outweigh the risk to tumor enucleation or abortion. The mobility and pliability of the recently delivered uterus, facilitate access to and control of the wounds left by excised myomata. The strongly retractile state of the uterine wall lessens the hemorrhage incident to enucleation. After Cesarean Section, the cervix must be patulous; at times the free escape of the lochia is assured only by artificial dilatation of the cervix. In thirty-eight cases, Cesarean Section was supplemented by hysterectomy. Nineteen of these were total; fifteen, subtotal or supra-vaginal. In four cases, Cesarean section and delivery of child were followed by supra-vaginal amputation of the uterus and adnexa, and the cervical stump was anchored to the lower angle of the abdominal wound (Porro operation).

#### HYSTERECTOMY.

In the treatment of fibroids complicating pregnancy, hysterectomy is a procedure of necessity. It is a radical mutilating operation, justifiable:

1. If the woman is near the menopause.
2. If enucleation prove impossible, because of location, volume, multiplicity of tumor or general myomatous degeneration of the organ, and if the tumor be of such dimensions and so situated that neither delivery per vias naturales nor progression to full term is possible.
3. If the patient is unwilling to undergo the risks incident to child bearing and refuses to wait for Cesarean section.
4. After Cesarean section to prevent pregnancies that would unduly endanger the maternal life; (contracted pelvis, rupture of the uterine scar, etc.) Hysterectomy avoids all future obstetrical complications while the following two possibilities militate against Cesarean section; (a) the seeping of uterine

- fluids into the peritoneal cavity; (b) spontaneous rupture of the uterus at site of the scar or near the same during another pregnancy.
5. If the cervix is distinctly abnormal by reason of lacerations, ulcerations, inflammation, or if there be the slightest suspicion of malignancy; in these cases, hysterectomy should be total.
  6. If after enucleation bleeding is profuse and not otherwise controllable.<sup>46</sup>

In hysterectomy total or supra-vaginal, the operator has the choice of two routes, abdominal and vaginal. For the condition under consideration, the latter is rarely employed. The removal of the uterus may be accompanied by the unilateral or bilateral removal of the adnexa. Unless diseased, the appendages should be left. When hysterectomy is to be performed, the supra-vaginal operation is to be selected, if it permits the total removal of the tumor. It is recommended to cut close to the vaginal insertion in order to avoid opening the ovum and the resulting outflow of liquor amnii.

Total hysterectomy is an operation of difficult technique and of some dangers. In 137 cases in which hysterectomy was performed (26 total, 111 supra-vaginal) there were ten maternal deaths.

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## CASE OF GUNDÚ OBSERVED IN BAHIA, BRAZIL.

By DRS. FERNANDO LUZ and OCTAVIO TORRES.

Translated from the Portuguese for the *Journal* by Dr. A. McSHANE, New Orleans.

The case which we have the pleasure of presenting to the Second South American Conference of Hygiene, Microbiology and Pathology, is very interesting not only on account of the lesions which the patient presented, but also on account of its rarity.

The present observation was made by myself and my distinguished colleague and friend, Professor Fernando Luz.

We shall not give the history of *gundú*, or *anakré*, for this can be found in every good text-book of tropical medicine. We will merely mention that the first case observed in America was reported by our friend, Prof. Pacheco Mendes, of Bahia, in a mulatto (1), who was operated on by the same professor, who endeavored to make anatomical and histo-pathological studies of the excised part.

The photographic studio of the College of Medicine in Bahia has a photograph of a patient with *gundú* in a negro, which was reported by Dr. John Gouveia, a physician of the hospital. The photograph was ordered by an assistant of the faculty. The case that we are about to report was also in a mulatto.

Manoel F., mestizo (mulatto), native of Bahia, living in the city of San Francisco (district of Santo Amaro), about sixty years of age, stone-cutter, entered Santa Isabel Hospital in the beginning of 1916, in a clinic under the care of one of the professors of medical clinic.

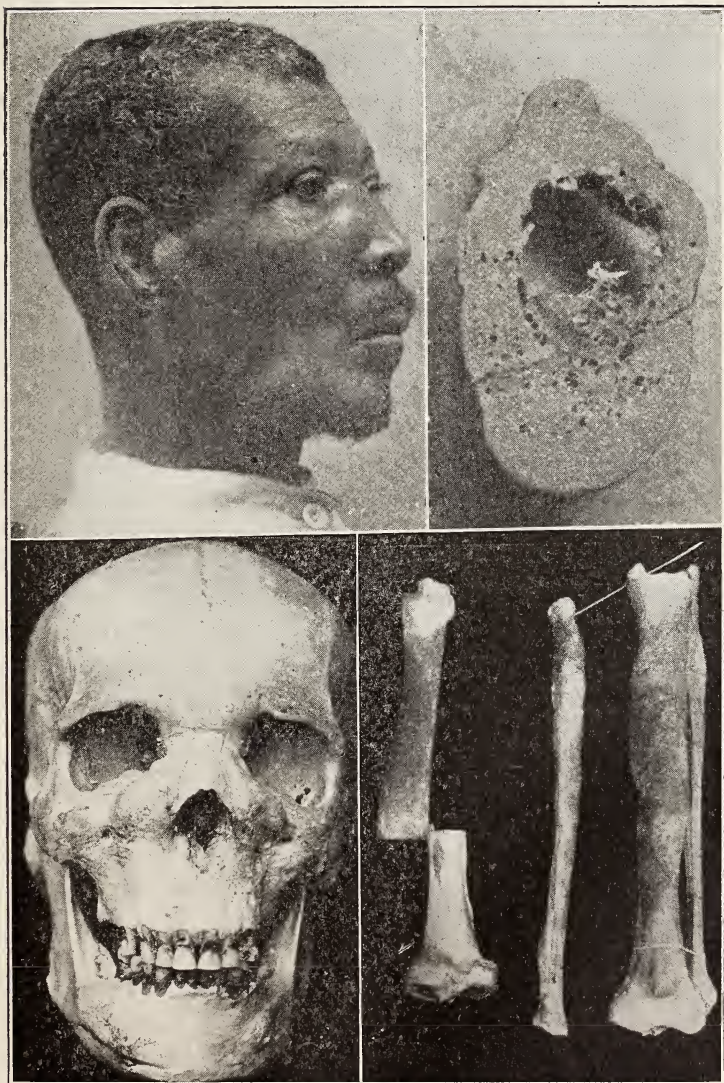
This illustrious colleague examined the patient, and ascertained that he was not dealing with a case properly belonging to this clinic, and he transferred him to the clinic of Professor Fernando Luz, who immediately made a diagnosis of *gundú* or *anakré*.

In collaboration with Prof. Luz we studied this case with great interest.

Our questioning did not advance matters much, on account of the ignorance and stupidity of the patient. However, we did manage to extract the following information: both parents are dead; he has no brothers living; he does not know what they died of; he did not know if his mother had any abortions; his own personal antecedents are of no importance.

(1) Pacheco Mendes: A propos d'un cas de Gondou ou Anakré. *Revue de Chirurgie*, XII, 1901, Page 495.





Illustrating Article of Dr. Torres.

He does not remember when his disease began. He entered the hospital because he was no longer able to work, and because he had some parasites in the skin of his feet (*Sarcopsilas penetrans*).

On examining the patient, we found the following: two tumors at the root of the nose; two swellings, each three centimeters in length and one in width, situated one on each side of the inferior maxilla and one centimeter above the free border of the latter; exostosis of the following long bones: ulnas and radii; tibia and fibula, several ribs, the humeri, clavicle, metatarsal bones, and some metocarpal bones.

Besides this, the patient had hypertrophied mammillæ; genital organs apparently normal; poor development of hair; and the feet turned outwards, making an angle of more than ninety degrees; the inner border of each foot did not follow a straight line, but each border formed an obtuse angle of 160 degrees outwards at the level of the tarso-metatarsal articulations.

Examination of the internal organs revealed nothing, as they function perfectly. He was anemic and his mental development was very rudimentary.

The blood, feces and urine were examined. The Wassermann reaction was made by our colleague, Dr. Aggrippino Barbosa; it was negative. In the feces were found ascarides and tricocephalus. In the urine, nothing of importance was found. The blood count was as follows:

Red corpuscles.....	2,520,000	per each milliter
White corpuscles.....	6,230	per each milliter
Hemoglobin (Tallquist).....	50	per cent.

Differential blood-count:

Polynuclear neutrophiles.....	57	per cent.
Polynuclear eosinophiles.....	8	per cent.
Transition-forms.....	4	per cent.
Large mononuclears.....	4	per cent.
Large lymphocytes.....	21	per cent.
Small lymphocytes.....	6	per cent.

The patient remained under observation in the Surgical Clinic of Prof. Fernando Luz, and then we carried on our inquiries for the purpose of ascertaining the cause of the disease.

As the disease progressed, there appeared a paralysis of the lower limbs and a relaxation of the sphincters. Some days later a severe diarrhea came on, and we were obliged to transfer him to

the isolation department of the hospital, with a request to inform us concerning the future course of the disease.

The patient died a few days later; but we did not learn about it until the patient had been buried three or four days.

We had planned to make a minute necropsy, and to make cultures, sections of the diseases, tissues, etc.; but, for the reason above stated, this was impossible. However, we obtained, through the courtesy of Prof. Oscar Freire, Director of the Nina Rodrigues Institute, of Bahia (Medico-legal Section), acting in accord with the head of the Casa da Santa Misericordia, permission to exhume the remains and perform a necropsy, which was done by the eminent master and colleague, Prof. Oscar Freire, assisted by Drs. Almir Oliveria and Fernando Luz, and myself.

The cadaver was exhumed six or seven days after burial. As it was impossible to hold a regular autopsy, we decided to remove several pieces; so, we took away the head and both legs, not disturbing the rest, although all the infected parts were interesting. We made photographs of the structures removed, which are presented herewith.

The lesions were as follows: pyriform tumors of the ascending apophyses of the superior maxillary bones, which encroached slightly on the lower border of the orbit and the nasal fossæ, gradually diminishing towards the malar bones; on the lower maxilla, there were two tumors three centimeters in length and one and a half in width, lying parallel with the maxillary border. These tumors were of the same nature as those above described (see photograph).

Small exostoses of the cranium, which were perceptible during life, were more evident after death.

The tibiae and fibulas, which presented large exostoses, easily seen in photograph, were the seat of interesting lesions (see photograph). The lesions are seen to be clear: the tibiae have lost their anterior border in their entire length, and were almost doubled in thickness, the tumors being best developed in the lower two-thirds. There was close union between these bones and the fibulas, which were adherent at the upper and lower ends. The tibial *plateaux* showed exostoses laterally.

The thickened fibulas seemed to be twisted on their long axis, being thickest in the lower two-thirds. In the upper third (see photograph), we see perfectly the union of these two bones with the tibiae.



Apparently, the long lesions are those of osteo-porosis.

In the photograph, the two bones are united as by a cord; and since the manipulations through which they passed threatened to break this union, the bones were prepared as shown.

We made longitudinal sections of one of the tibias, not only to see the shape of the bones but also to study the medullary canal.

The dimensions were visibly increased in all directions; the medullary canal was extremely reduced, presenting a small orifice, which was not sharply limited, but was lined by a kind of reticulated bony tissue, the deeper portions of which blended with the cavity of the bone (rarefying osteitis).

From photograph, which was partly destroyed by the saw, this tissue was well developed.

On the posterior surface of the tibia, a well developed bony ridge is seen.

On transverse section, we distinguished tissues which seem to be of a different character.

Thus we find one part very porous, spongy, corresponding precisely to the anterior border and the two surfaces; and on the other hand, there exists a ridge of the same kind of tissue; and deeper in we find a small semicircular patch that has a cartilaginous aspect.

Sections were made of the bony tissue, and these are now being studied from a histo-pathological standpoint by the eminent Prof. Bowmann Crowell, at the Oswaldo Cruz Institute.

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## DRESSING FOR FRACTURE OF THE CLAVICLE.

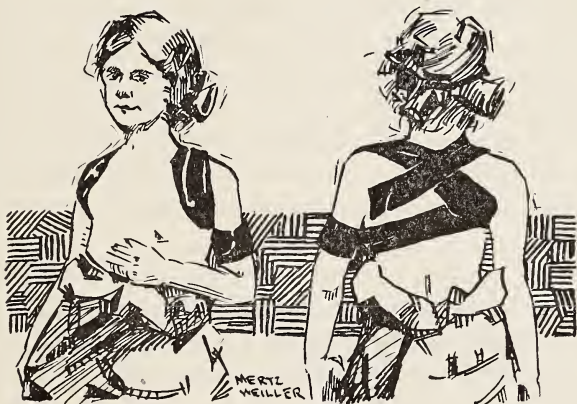
DR. E. L. LECKERT, New Orleans.

I have adopted for several years, a method of immobilizing fractures of the clavicle in children which may be worthy of mention. While nothing original is claimed, a combination of other methods being used, it has given entire satisfaction both from a clinical standpoint and as a comfortable dressing. In our climate, the use of Z. O. plaster next to the skin causes such irritation and discomfort as to make its use impracticable. Bandage dressings require frequent changes, as they become loose even though reinforced with Z. O. plaster. Axillary pads are difficult to retain.



The material needed is usually in the house, and the dressing can be applied on the first visit.

Method: A piece of cloth long enough to make a posterior figure of eight about the shoulders, and four or five inches wide, is padded with cotton in each part that is to encircle the axillæ. The affected side is padded heavier, and if pressure is desired over the site of fracture, that part fitting over the clavicle, likewise.



The cloth is folded to two or two and a half inches, and sewed sausage-like. This is applied as a posterior figure of eight bandage, and after drawing the shoulders fully back which in most fractures reduces the deformity, the ends are firmly sewed together. This dressing acts as a reduction and retentive bandage and an axillary pad. A second piece of cloth is padded on one end for several inches, and likewise folded and sewed. The padded end is placed around the arm on the affected side and sewed. The arm is well drawn back, and the free end is sewed to the lower opposite part of the figure of eight. Some elevation of the shoulder is thus obtained, and complete immobilization of the arm. A sling may be used.

If care is exercised in applying the dressing, it will remain snug for a week or more. However, should it become loose, a few extra stitches will be necessary from time to time. The entire dressing is changed when soiled.

## COMMUNICATION

## IS TRACHOMA PREVALENT IN NEW ORLEANS?

New Orleans, August 10, 1920.

To the Editors of the *New Orleans Medical & Surgical Journal*:  
Gentlemen:

I quite agree that medical controversies are to be deprecated; but where an important truth is in question they should not be shrunk from. It is needless to say they should be conducted with decorum, less the laity be given ground for retwisting their favorite gibe on the disagreement of doctors. As if the verities of constantly advancing science and art could be established save by the gradual accumulation of evidence and the conflict of mind with mind over its validity.

During the meeting of the A. M. A. in New Orleans, I took part in the discussion before the section on Public Health of a paper by Dr. J. W. Jervey, of Greenville, S. C., in the interest, I believe, of truth and justice. In my little paper I made use of the expression, that, were anyone suddenly to assert the prevalence of trachoma in New Orleans, I should think myself bound to take up the cudgels in defense of my community. These were the words, I think, certainly the sense of my remark. Dr. T. J. Dimitry, who was present, evidently understood my meaning, as his declaration, later, that he proposed "to throw the cudgels on the opposite side," showed. When I heard, therefore, that our confrere was going to read a paper before the Orleans Parish Medical Society maintaining his opposition to my expressed belief, I went to the meeting and participated in the discussion.

My talk was entirely extempore and, I expect, was rather rambling and long drawn out, as such talks usually are. I supposed that it would be taken down in short-hand and afterwards, according to custom, would be submitted for revision and could then be pared down to the kernel. Later, I was surprised when asked to supply in writing what I had said. I was of course, unable to do so. It is on this account, because the matter is undoubtedly of no small importance, that I now beg space to present as briefly as possible the reasons for disbelieving that trachoma is prevalent in New Orleans or in Louisiana. I hope to show that the facts are

so apparent that no extended investigation is necessary to uncover them.

The first half of Dr. Dimitry's title, Trachoma Exists in New Orleans, is an assertion that no one controverts, or so far as I know has ever controverted. When I saw the disease in the Charity Hospital some 35 years ago and gained the lasting impression that it was found for the most part among foreigners who came to winter here, I never fancied myself a discoverer. Since then prolonged experience has fostered the belief, which the doctor must often have heard me declare, that trachoma is rare among our creole population, the descendants of the French and Spanish immigrants of long ago. It is inconceivable that any one would maintain, favored though we may be, that the mere privilege of being born within the Pelican State could confer immunity to the disease. But all this is very different from saying that trachoma *prevails* among our people; prevails to such an extent as to constitute a grave danger; to justify alarming them, introducing a new phobia, and courting the risk of disagreeable and injurious outside interference.

Yet, I submit this, in spite of his title, is just what Dr. Dimitry's paper and his unpublished argument closing the discussion upon it imply. If this implication was not intended, what was the object of the paper; what the necessity of "throwing cudgels" against one who expressed a contrary belief? Hardly to prove what every one admits and what our hospital reports have been showing for many a long year.

First, as to the introduction and spread of trachoma in Europe, its prevalence in foreign countries or its distribution in this, I shall say nothing. It merely serves to distract attention from the question at issue and can readily be found in our text-books and cyclopedias. I shall be equally silent on the application of such names as "insurgents," "obstructionists," etc., to those who differ from us in opinion. They have no place in scientific discussion and need no reply.

To begin with, then, the prevalence of trachoma cannot be proved by the collection of fifteen or twenty—or fifty or a hundred—cases out of a population of four hundred thousand. Every ophthalmologist will admit that even a greater number might be brought together in almost any city of a hundred thousand inhabitants, especially by looking through the public schools and eleemosynary institutions. Indeed, when we consider that Dr. Dimitry has for

some time been devoting his attention to trachoma, as we know by this and another paper read before the Parish Medical Society and an interview in the public press, and that he has asserted, to his confreres at least, his invention of a method of cure, the small number of cases he exhibited tends to show rather the rarity than the prevalence of trachoma among our population. The argument as to the liability of the creole is the same. Even in the negro, perhaps we should say the southern negro, whose relative immunity has been admitted by almost all who have treated great numbers of the race, cases may be found now and then. The presentation, therefore, of a few afflicted ones out of our large creole population cannot be called decisive evidence. Whether this relative minority is a fact or merely a phenomenon due to the general rarity of the disease in Louisiana, and, if it be a fact, to what prime cause it is to be ascribed, are admittedly unsettled questions.

Although there are well known places in which trachoma is endemic among a population of long and pure American descent—for instance the inhabitants of the great Appalachian Mountain range—it is a commonplace of observation that where ever the population is mixed, the disease is found much more frequently among the foreigners, their immediate descendents and that part of the American population which lives in close contact with them. The reason is transparent; trachoma is a disease of poverty and its concomitant squalor and becomes rarer as wealth, and the improvement in hygiene it makes possible, increases. Cases are always seen much oftener in hospital than in private practice. Dr. Victor C. Smith and Dr. Chas. A. Bahn, the two ophthalmologists who also took part in the discussion, emphasized this point. Dr. Bahn, among 750 private patients seen since his return from military service, found but five (5) cases, three old and two recent “and two suspects later proven not to be trachoma.” Dr. Smith said, “I seldom see a case of trachoma and rarely in my private practice.” He added that his associate in hospital practice, Dr. Marcus Feingold, had had the same experience. My own coincides.

The statement of Dr. J. B. Guthrie, during the discussion, that among seventeen hundred troops from Louisiana, Mississippi and Arkansas only twenty-six cases of trachoma were discharged from the service during nine months, of whom the smallest number were from Louisiana, throws a strong ray of light upon the subject.



Dr. Dimitry, who had served with him on a Local Medical Examining Board during the world war, was asked by Dr. F. W. Parham if he knew what percentage of drafted men from New Orleans were rejected on account of the presence of trachoma or its sequelæ, but he was unable to say. Through the courtesy of the Surgeon General, U. S. A., I am able to give the figures so far as they are available. "Statistics have been compiled in this office for all men rejected by the various Local Boards and 2,000,000 of the 2,700,000 selective service men who were sent to military camps. Unfortunately there was no information recorded on the physical examination form to show the color of the registrant or his age. It may, however, be presumed that the figures quoted below are for men between the ages of 21 and 30, as few, if any, registrants of any other ages were inducted; of men of this age in the city of New Orleans 13,403 were examined by the Local Boards. Three thousand and eighty (3,080) were rejected as physically or mentally unfit for all military service. \* \* \* \* \* Below is a table showing the total eye defects of various kinds which were noted in the registrants from the city of New Orleans. \* \* \* \* \* The ratios that are given are proportioned to each 1,000 men examined in the city. If you attempt to verify these ratios by the number of men examined, you will obtain different ratios, for as stated above not all the men who were sent to military camps were studied statistically." The table referred to shows: "Trachoma (conjunctivitis granular) absolute numbers 9, ratio .82" (per 1,000).

The statistical tables appended to the report of the Surgeon in Charge of the Eye Department of the Eye, Ear, Nose and Throat Hospital for the ten years from 1907 through 1917 (that for 1914 being omitted on account of defective compilation) shows that during the decade 34,388 cases were seen of which 5,830 were diseases or injuries of the conjunctiva; out of this number 186 were trachoma in white and 17 in persons of color—between 5 and 6 per 1,000. The percentage of error is certainly small, because the diagnosis in every case was made by the surgeon in charge of the department and every case of folliculosis at all suspicious was treated under a provisional diagnosis until the result made certain its nature.

In conclusion, a word may not be amiss on the differential diagnosis between trachoma and folliculosis and on the curability of true trachoma. I have yet to hear of an ophthalmologist past the

embryonic stage who demands that the lids should be filled with scar tissue or that pannus should be present to enable him to make a diagnosis. Unfortunately, that there are many cases in which a diagnosis cannot be made at once is not an individual opinion, but is generally admitted. Not to overload this communication, let quotation, for the present be restricted to three most authoritative texts in general use. Each author deals carefully with the differential diagnosis between folliculosis and trachoma and each in all candour is driven to these conclusions. Says Fuchs (3d Amer. Ed. 1908, p. 83) "the correct diagnosis can be made as a rule by our finding the conjunctiva studded with numerous granules. But if these are absent during the first days of illness, or if because of the great swelling of the conjunctiva, they are not apparent, the subsequent course of the disease may be the only thing that can clear up the nature of the latter." And again on page 98: "But these characteristics are sometimes so obscured that even experts cannot, in many cases, make the diagnosis with certainty and the subsequent course of the disease alone affords the desired information."

Roemer (Foster's translation, 1912, V. I. p. 105): "and such a differentiation is by no means always easy. \* \* \* \* \* "We must be content in many cases with a diagnosis of 'trachoma (?)'. The subsequent course and the results of treatment will differentiate the benign forms because they readily get well" p. 114.

DeSchweinitz (8th Ed., 1916, p. 218): "Certainly so called benign follicles exist which disappear without a residue of lesions, and, on the other hand, an infection with follicular formation arises which subsides after a long period of time and leaves cicatrices. Between these two forms are the 'border line' cases which are difficult to classify."

If by cure Dr. Dimitry means the restoration of the trachomatous conjunctiva to its normal state and function, and the positive expressions he uses seem to indicate such a belief, then he must be wellnigh alone in his faith and the burden of proof he assumes is enormous. The evidence adduced must be abundant and clearly and minutely set forth. Every one admits that trachoma may be arrested, after leaving lesions of greater or less extent, and even those of small experience know that relapses are the rule rather than the exception.

To quote once more from the authorities above cited: "In the

subsequent course of the disease the hypertrophy of the conjunctiva gradually increases, growing steadily greater, until it has reached a certain height, which is not the same in all cases. Then it disappears again, step by step, while a cicatricial state of the conjunctiva takes its place. In this way the trachoma is cured in the sense that the specific morbid process has come to an end. Nevertheless the conjunctiva has not become normal again by any means; on the contrary it bears upon it lasting marks of the disease that has passed." (Fuchs, l. c., p. 80).

"In other cases the disease gets well with comparatively slight scars, and this may even occur without any treatment, inasmuch as the hypertrophy of the conjunctiva attains only a moderate pitch and then spontaneously abates." (p. 83). "Trachoma then is a disease which is distinguished by its duration, extending over years" (p. 87).

"The name trachoma should be applied only to such diseases of the conjunctiva as are able to inflict permanent injuries upon the eye, to those only in which the hypertrophy of the conjunctiva ends in the formation of cicatricial tissues." "Any granular disease of the conjunctiva that results in cicatrization is trachoma." (Roemer, l. c., pp. 105 and 112).

"An infection with follicular formation arises, which subsides after a long period of time and leaves cicatrices (deSchweinitz, l. c., p. 218).

These unqualified statements of the result of their experience by such observers do not tend to encourage in any man the conviction that he has cured trachoma and such an assertion imposes, I repeat, a great burden of proof.

The reason of this difficulty in diagnosis is not far to seek. All pathologists, I believe, agree with Fuchs that "even in the histological structure no thorough-going distinction can be found between follicles and trachomatous granulations." No absolutely specific organisms have been found invariably associated with trachoma, though Dr. de Schweinitz thinks that the finding of Prowazek bodies "is highly significant. Their absence, however, does not exclude trachoma." The difficulty is enhanced by the fact that secondary or mixed infections are notoriously common with trachoma, and a great variety of appearances are thereby produced. It would seem that trachoma is a folliculosis of the conjunctiva, acute, probably, only when the infection is mixed, to which some

unknown element is added causing hypertrophy and subsequent cicatrization of the conjunctiva. This element, up to the present time, all our efforts have failed to reveal.

H. DICKSON BRUNS, M. D.

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### OBITUARY.

In our last issue we made a brief record of the death of Dr. Robin, who died on July 9th, 1920.

He was the son of Ernest Robin and Pamela Favre. Born on his father's plantation near New Roads, Point Coupee Parish, fifty-one years ago, he was first of all, by breeding and instinct, a gentleman.

Educated at the Jesuit College of this city, he received the B. Sc.; after having served as a Resident Student in the Charity Hospital, he graduated in medicine in 1891 from the Tulane University of Louisiana.

For a short time after his graduation he practiced General Medicine, while living with his father's sisters at their home in St. Charles Avenue. He grew interested in the study of ophthalmology when assigned to the "Eye Wards" for part of his term in the Charity Hospital, and cherishing a wish to devote himself to that branch of medicine, as soon as he saw his way, he applied for and received an appointment to the staff of Visiting Oculists to that Institution. There he worked with such zeal and intelligence, that in 1895 he was called to the position of First Assistant Surgeon in the Eye Department of the Eye, Ear, Nose and Throat Hospital. He now turned all his energy and ability to this service and his rise was sure and steady. Visiting the clinic daily for many years, he enlarged his diagnostic and therapeutic knowledge, perfected his surgical skill and broadened his experience, by the study of the great number of medical and surgical eye cases seen year after year in this department of "The Senses Hospital." His elevation to Surgeon in Charge of the Department took place in 1914. Meanwhile, after having held for several years the position of First Assistant to the Chair of Diseases of the Eye in the New Orleans Polyclinic (Graduate Department of Tulane University), then that of Assistant Professor, he was in 1904 promoted to a full professorship. These appointments, which he held at the time of his death, crowned the ambition of his life of long and useful labor. In 1895



he visited the important European eye clinics, spending most of the time in Paris, under Panas, and in Vienna, under Fuchs. The only other incident of interest in his professional career was the partnership with his friend and old hospital chief of more than thirty years, Dr. Henry Dickson Bruns. This was entered into in 1898 and continued in amity and mutual respect and confidence for twenty-two years.

He was a valued collaborator on the staff of the *JOURNAL*.

Dr. Robin married Miss Mary Titus, of this city. Comforted by her constant affection and care and by the fond companionship of their sons, Ernest and Marion, the smooth current of his domestic life flowed with unbroken happiness.

In character Dr. Robin was courageous and self-reliant. A strong sense of justice and a love of truth made him punctilious in the discharge of every obligation. As a companion, he was cheerful and entertaining; as a friend, ready and loyal. These qualities led naturally to a constant interest in political affairs and to the unflagging performance of his duties as a citizen. His mind was clear and logical and his highest pleasure was to store it with information drawn from well-chosen sources by discursive reading in two languages. Though French was the language of his infancy and he continued to draw intellectual enjoyment from its nice refinements, he read with attention what is best in English until he wrote and spoke it with particular exactness and with entire freedom from Gallicisms.

Dr. Robin was not a prolific writer, but what he wrote was terse and to the point; drawn from his own store of observation and reflection and little dependent upon the authority of others. He contributed to our knowledge of the tuck-operation for shortening the recti muscles, of the ambulant after treatment of cataract operations and of the method of extraction of the opaque or dislocated lens by the use of a long conjunctival bridge. He demonstrated this operation at the meeting of the American Medical Association to his confreres of the ophthalmic section from other states; for of all operators in our country, he had perfected this mode and made it his own and was able to show by a long series of successes that it is not only the procedure par excellence for the removal of a dislocated lens, but the best means of averting loss of vitreous and infection of the wound when these grave complications are most to be dreaded in the extraction of senile cataract.

As a teacher Dr. Robin was pleasant, wide ranging and exact. He stimulated his pupils to think for themselves. They grew not only to admire him as their instructor, but to esteem him as a man and a friend. Hundreds of them scattered throughout the south will mourn his death with a sad sincerity.

The loss of such a man may not be well supplied. Where character is admired and scientific attainment respected, his death should be lamented, his talent praised, his services extolled. If panegyrics are pronounced over him who accumulates wealth, increases industry or commerce, multiplies employment, and devises new apparatus, some meed may be afforded him, who, turning from material rewards, devotes his life to acquiring, amplifying and disseminating knowledge of the art that fights against man's fate, against the calamity that men almost universally hold to be worse than death.

Saved by a sense of humor, free from pretense and despising it in others, too proud to put his lips to the trumpet of his benefactions, the first to own that they were but part and parcel of his daily duties, this man in expenditure of time, in scorn of delights and the living of laborious days, gave to the poor of his city an incomputable sum of help, of hope, of deliverance. The forehead of the philanthropist is worthy of the laurel; may not one leaf be allowed to fall upon the brow of such a one as Ernest A. Robin?

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## NEWS AND COMMENT

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DR. J. BIRNEY GUTHRIE, CHAIRMAN, SCIENTIFIC ESSAYS COMMITTEE, announces a resumption of the scientific sessions of the Orleans Parish Medical Society, with the opening (post-vacational) meeting to be held September 13th, 1920. This meeting is to be a "Symposium on Mental Disorders," under the direction of Dr. R. M. VanWart. As considerable effort and research work have been put forth to make this meeting a scientific success a large attendance is anticipated.

CIVIL SERVICE EXAMINATIONS.—The United States Civil Service Commission announces open competitive examinations for positions as Bacteriologist, Associate Bacteriologist and Junior Bacteriologist on December 1. Applicants should at once apply for Form

1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., or to the Secretary of the United States Civil Service Board, Customhouse, in their district. Applications should be properly executed, including the medical certificates, and filed with the Civil Service Commission, Washington, D. C., without delay.

**TURKISH MEAT PACKERS REFORM.**—Meat packing is being revolutionized in many Constantinople establishments since the advent of the American Red Cross. At the Refugee Camp of the Island of Proti where that organization is caring for thousands of refugees, the meat was arriving in the usual Turkish style, the carcasses hanging in packing boxes, left open on one side for easier handling, and strapped to a donkey. Flies and germs held revel all the way from the docks to the warehouses. "Right about face" ordered the Red Cross officers and the Turkish vendors seeing that they must either conform to these unheard of standards of sanitation or lose a profitable patronage, mended their ways.

**MEMORIAL TO BE DEDICATED BY JEFFERSON MEDICAL COLLEGE.**—As a tribute to those graduates who gave their lives in the service of their country during the late war, the Alumni Association of Jefferson Medical College has planned to dedicate a memorial, which will be in the form of a large bronze tablet, 5 feet high by 4 feet wide. The tablet will be decorated and engraved with the names of the men who surrendered their lives in the service, and will be placed in the main entrance to the college at Tenth and Walnut Streets. Dedicatory ceremonies will be held in the college building on Thursday, October 7, 7 P. M. Jefferson Medical College was represented in the war by 1147 graduates, twenty-five of whom gave up their lives.

**ACTIVITIES OF ANESTHESIA SOCIETY.**—Announcement is made by the National Anesthesia Research Society that at their annual meeting to be held in Pittsburgh, October 4 to 8, its research workers will present the results of their experiments and observations. Prizes of \$200 have been offered for the best papers submitted. The Toledo Society of Anesthetists has been organized with a 100 per cent enrollment of all recognized anesthetists of the city. It is reported that fourteen county societies in California have adopted resolutions favoring the limitation of the administration of anesthesia to regular licensed physicians and surgeons.

ANTHRAX NOT FATAL.—A statement by Dr. Douglas Symmers, director of the Pathological Laboratories of Bellevue and Allied Hospitals on the recent discharge of a well known polo player suffering from anthrax, the claim is made that the disease is not fatal if treatment is begun early. This is the the fifth case reported by Bellevue as being cured with the serum prepared by the United States Department of Animal Industry.

NEW YORK ON GUARD AGAINST PLAGUE.—Health Commissioner Dr. Royal S. Copeland, with the \$80,000 recently given to the Department of Health by the Board of Estimate for the purpose, plans to begin an active campaign to guard against an invasion of the plague that is now ravaging sections of Europe. The health department has taken up the work of educating the public regarding the prevention of the disease. It is the intention of the Health Commissioner to extend the work of exterminating the rats along the water front.

MISSOURI VALLEY SOCIETY MEETING.—The Medical Society of the Missouri Valley will hold their thirty-third annual meeting in Omaha, September 6 to 7, under the presidency of Dr. Charles Ryan, of Des Moines, Iowa. The society will be the guest of the Omaha-Douglas County Medical Society.

CANADA UNIVERSITY NEWS.—An offer of a Red Cross Chair of Public Health has been made the University of British Columbia by the Provincial Red Cross of British Columbia. The Red Cross will pay the salary of the professor of public health for three years. The activities of the department will be province-wide. The course will extend over a period of five years. The Faculty of Medicine of the University of Toronto has prepared a survey for the Rockefeller Foundation, which shows Ontario in the lead with one physician to every 905 population. British Columbia comes next with one to 906, Nova Scotia third with one to every 908, and Manitoba fourth with one to every 1,098.

MASSACHUSETTS CENTRAL HEALTH COUNCIL.—For the purpose of cooperation between the various health agencies throughout the state a General Health Council has been organized in Massachusetts. The new organization will consist of representatives from the public health nursing, child welfare, medical and dental groups, tuberculosis, cancer, state and local health officials, the Red Cross, and the American Public Health Association. Dr. Enos H. Biglow, of



Framingham, has been made president. By means of this organization it is expected to eliminate the duplicating and overlapping of duties.

**WISCONSIN UNIVERSITY TO GIVE FULL MEDICAL COURSE.**—By the terms of legislation recently enacted the medical course of the University of Wisconsin will be expanded to a complete four year course. This university has heretofore given only two years of medical instruction. The teaching of the third year will it is understood be offered in the fall of 1923 and that of the fourth year in the fall of 1924. A state hospital will also be established at Madison.

**SANITARY CODE AMENDED.**—In order to prevent anthrax the Sanitary Code of New York City has been amended to provide for the sterilization of hair used in toilet articles. The sterilization must be in accordance with the rules of the Board of Health.

**COMMISSION ON MEDICAL EDUCATION.**—Virginia has appointed the following medical men as a Commission on Medical Education: Dr. Beverly R. Tucker, of Richmond; Dr. James H. Dillard, of Charlottesville; Dr. Julian A. Burrus, of Blacksburg; Dr. Stuart McGuire, of Richmond, and Dr. Theodore Hough, University of Virginia. The commission has been appointed to make recommendations leading to the establishment of a single medical school in Virginia to be state supported.

**MEETING INTERNATIONAL SURGICAL CONGRESS.**—The fifth International Surgical Congress meeting was held in Paris, July 19-22. Representatives of thirteen nations presented papers. Clinics were held in various hospitals of Paris during the mornings; the scientific program being carried out in the afternoons and evenings. Sir William MacEwen, professor of surgery in Glasgow University, was elected president. The date of the next meeting was fixed for July 16, 1923, with London as the meeting place.

**RED CROSS ROLL CALL.**—Plans for the Fourth Roll Call of the American Red Cross have been set forth by Frederick C. Munroe, general manager. Armistic Day, November 11, and Thanksgiving Day, November 25 have been set on which the call is to take place.

**APPROPRIATION FOR RADIUM.**—An appropriation of \$225,000 by the state legislature of New York recently, enabled the New York

State Institute for the Study of Malignant Diseases, in Buffalo, to purchase two and one-quarter grams of radium, which will be available on and after October 15. Preference will be given to residents of New York State, but any citizen of the United States will be treated free of charge. The director of the Institute is Dr. Harvey R. Gaylord.

HONORARY DEGREES CONFERRED.—The honorary degree of Doctor of Laws was recently conferred by Cambridge University upon Dr. John Jacob Abel, professor of pharmacology at Johns Hopkins Medical School, and Dr. Harvey Cushing, professor of surgery at Harvard Medical School.

MEDICAL JOURNAL IN PALESTINE.—A new medical journal published by the Jewish Medical Association of Palestine has just made its appearance. The new publication will be published quarterly and entitled Harefoosh (Medicine). The American Zionist Medical Unit has greatly stimulated medical work in Palestine during the past two years; native members of the profession being taught modern methods. It is planned to utilize the hospitals and clinics established by the American unit as a beginning for the Medical College of the Hebrew University at Jerusalem.

NEGRO PHYSICIAN FELLOWSHIPS.—Mr. Julius Rosenwald of Chicago recently provided six fellowships for negro physicians, in amounts of \$1,200 each. These are to pay the expenses of qualified negro students doing graduate work in the fundamental medical sciences.

MEDICAL EDUCATION DONATION.—Mr. John D. Rockefeller during the year added another \$20,000,000 to the general education fund which is to be used for the improvement of medical education in the United States. The interest and principal is to be distributed within the next fifty years.

DECREASE OF DRUG ADDICTS IN CANADA.—By a report of Dr. John R. Amyot, Toronto, deputy minister of public health success is shown in the efforts of the department of health to wipe out the opium evil in Canada. The department also met with success in breaking up attempts to create an opium ring in the Dominion. On September 1, the opium and narcotic drug act, passed at the last session of Parliament will become effective. Under the act all druggists, wholesale and retail, and all manufacturers will be

compelled to keep a record of receipts, together with a record of the quantity manufactured as well as a record of their sales.

PERSONALS.—Dr. G. A. Thomas of New Orleans, recently returned from service in the army.

REMOVALS.—Dr. Elliott Kiblinger, from Marksville, La., to 204 Hughes Building, Dallas, Texas.

Dr. O. F. Howe, from Kerens, Tex., to Thorndale, Texas.

MARRIED.—On August 18, Dr. Andrew V. Friedrichs to Miss Anna Crawley, both of New Orleans.

On June 23, Dr. George W. Faivre to Miss Julia Leidenheimer, both of New Orleans.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

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**A Diabetic Manual for the Mutual Use of Doctor and Patient**, by Elliott P. Joslin, M. D., 2nd edition. Lea & Febiger, Philadelphia and New York, 1919.

The personal experience of the reviewer, who has given this manual to a considerable number of his diabetic patients, has convinced him of its great value in aiding him to secure the best attainable results in the treatment of these cases. However, it is not only as a guide to the patient that this booklet is of value, for it contains, in readily assimilable form, the most important facts and measures bearing on the treatment of diabetes. Consequently the physician wishing to familiarize himself with the newest and best methods of treating this disease will find in it a concise, clear, and correct statement of these things. The work is unqualifiedly recommended.

J. T. HALSEY.

**Pasteur, The History of a Mind**, by Emil Duclaux. Translated by Erwin F. Smith and Florence Hedges. W. B. Saunders Company, Philadelphia and London.

The translators of Duclaux's work pay large tribute to the author, who himself was no small factor in the development of micro-biology. As the co-worker and spirited contemporary of Pasteur, later serving as director of the Pasteur Institute in Paris, Duclaux was indeed qualified for the task of interpreting Pasteur. It has been a worthy task for the translators to place this work at the disposal of readers in an English version.

The text itself is full of interest as it unfolds the development of

the great genius and inspiring philosophy of the wonderful Frenchman, who cast the mold in which the present science of medicine has since drawn most of its methods. As a contribution to the knowledge of Pasteur, Duclaux's commentary must be always valuable; the translators deserve the credit of recognizing and transposing the original French into readable English. The book carries chronological prints of Pasteur which in themselves enhance the value of the book.

DYER.

**A Manual of Physical Diagnosis**, by Austin Flint, M. D., LL. D. 8th Edition, revised by Henry C. Thatcher, M. S., M. D. Lea & Febiger, Philadelphia and New York.

Perhaps a reviewer in commentary on this standard guide in diagnosis can do no better than quote from the preface to the 8th edition, which justifies its continuance with revisions, by stating that it is a response to the "demand of the student and of many graduates for simplicity, directness and skill in dealing with physical signs in health and disease." In such particular this work will continue to satisfy the demand.

DYER.

**Manual of Psychiatry**. Edited by Aaron J. Rosanoff, M. D. Fifth Edition. John Wiley and Sons, New York; Chapman & Hall, London.

After four years this collaborative work appears in a new edition. Reflecting the French school in earlier editions, this Manual still follows its original source, the work of J. Rogues de Fursac, in the arrangement of the material, though the editor with other American specialists in psychology and psychiatry have added materially to the content and to the value of the book. While in nowise intended as an exhaustive study of psychiatry, this work covers a large amount of ground and in all particulars it is well done. The chapter on Psychanalysis is a close commentary on Freud and his teachings, although other disputants are given some show. Of particular value are the many references and the plentiful bibliography. Modern in its presentation and practical in its scope, this Manual deserves a place among current reference works in psychiatry.

DYER.

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## PUBLICATIONS RECEIVED

**J. B. LIPPINCOTT COMPANY**, Philadelphia and London, 1920.

*International Clinics*, Volume 2, thirteenth series.

*Diagnosis and Treatment of Brain Injuries*, by William Sharpe, M. D.

**W. B. SAUNDERS COMPANY**, Philadelphia and London, 1920.

*Human Parasitology*, by Damaso Rivas, M. D.

*The Duodenal Tube*, by Max Einhorn, M. D.

**WILLIAM WOOD & COMPANY**, New York, 1920.

*Epidemiology of Tuberculosis*, by George E. Bushnell, Ph. D., M. D.

**CHARLES E. MERRILL COMPANY**, New York and Chicago, 1920.

*Healthy Living, Books One and Two*, by Charles-Edward A. Winslow, D. P. H.



**PAUL B. HOEBER**, New York, 1920.

Epidemic Encephalitis, by Frederick Tilney, M. D., and Hubert S. Howe, M. D.

**BONI & LIVERIGHT, INC.**, New York, 1920.

General Introduction to Psychoanalysis, by Prof. Sigmund Freud, LL. D.

**W. M. LEONARD**, Boston, 1920.

Diseases of Children, by John Lovett Morse, M. D.

**MASSON et CIE**, Paris, 1920.

Chirurgie Réparatrice et Orthopédique, Volumes 1 and 2.

**WASHINGTON GOVERNMENT PRINTING OFFICE**, Washington, D. C., 1920.

U. S. Department of Agriculture, Service and Announcements, Supplement. Notices of Judgment Under the Food and Drugs Act, July 1, 7, 26 and 27.

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A New Germicide for Use in the Genito-Urinary Tract: "Mercurochrome-220," by Hugh H. Young, M. D., Edwin C. White, Ph. D., and Ernest O. Swartz, M. D.

## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for July, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	2	1	3
Intermittent Fever (Malarial Cachexia)			
Smallpox	1	1	2
Measles			
Scarlet Fever			
Whooping Cough	1	2	3
Diphtheria and Croup	2		2
Influenza			
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	44	28	72
Cancer	38	4	42
Rheumatism and Gout		1	1
Diabetes		2	2
Alcoholism		1	1
Encephalitis and Meningitis	1		1
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	24	12	36
Paralysis	4	2	6
Convulsions of Infancy	1		1
Other Diseases of Infancy	19	9	28
Tetanus		2	2
Other Nervous Diseases	7		7
Heart Diseases	33	34	67
Bronchitis			
Pneumonia and Broncho-Pneumonia	7	14	21
Other Respiratory Diseases	1	1	2
Ulcer of Stomach	3		3
Other Diseases of the Stomach	1		1
Diarrhea, Dysentery and Enteritis	14	15	29
Hernia, Intestinal Obstruction	2	5	7
Cirrhosis of Liver	4	2	6
Other Diseases of the Liver	1		1
Simple Peritonitis			
Appendicitis	8	3	11
Bright's Disease	25	11	36
Other Genito-Urinary Diseases	10	6	16
Puerperal Diseases	6	3	9
Senile Debility			
Suicide	3	1	4
Injuries	27	17	44
All Other Causes	28	27	55
TOTAL	317	204	521

Still-born Children—White, 20; colored, 26; total, 46.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 13.12; colored, 22.25; total, 15.63. Non-residents excluded, 13.65.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmosphere pressure..... 30.05  
 Mean temperature..... 82  
 Total precipitation..... 6.20 inches  
 Prevailing direction of wind, southwest.

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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## EDITORIAL

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### EXAGGERATIONS AND REHABILITATIONS.

Under the above title Dr. Bouquet, of the *Monde Médical*, calls attention to what he terms the present day abuse of intravenous injections, used often as if they were the only means of obtaining an efficient therapeusis. Anything is injected in the veins, in any sort of case, in anybody; and upon reading the current literature one is tempted to wonder how patients could ever have been treated, and especially cured, in the days previous to the introduction of this innovation.

No one would think of denying that intravenous injections are a precious acquisition, but they should be reserved for such cases as require either specially rapid effect or massive action. They are indicated, for instance, to administer artificial serum in cases of cholera or other forms of collapse; also to arrest an early syphilis or to exhibit a remedy not tolerated by the stomach or hypodermically.

But why resort to them for giving salicylate of soda or bromides, as has already been proposed? They are not free from objections nor even from danger. They certainly are at times at least disproportionate in extent with the object in view. They frequently produce violent reactions; cases of embolism have resulted. The vein is sometimes missed, with more or less disastrous results, even by some who can be called neither ignorant nor awkward; and when the vein is reached all right, it does not follow that it may not be damaged or destroyed by the substance injected.

Besides it is known that greater rapidity of absorption also usually means quicker elimination, which frequently is not desirable. Further, it has been shown too that some remedies actually are more efficacious if introduced in the digestive tube.

Common sense should prevail in this matter as in all others. Use intravenous medication when clearly or urgently indicated, but be satisfied with simpler methods for more ordinary occasions.

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Every discovery in the medical sciences is followed by the summary execution of some truths of yesterday which have become errors of today. The enthusiasm for alkaloids has abated somewhat in the light of an increased knowledge of the more complex virtues included in the whole plant. The pendulum will swing. What is proscribed in the name of one theory is rehabilitated on the authority of another. Mr. Violle, in the *Presse Médicale*, calls attention to this in a very interesting article upon an obscure question, that of vitamines. In their name justice is rendered to fresh and natural products for alimentation to the detriment of the sterilized and ultra pure preparations which have been so highly praised up to now. Fresh fruit and vegetables will thereby be brought back on our own tables crowded with a halo of new virtues. Even good old-fashioned broth will be restored to favor in the name of vitamines. Exploded the idea that when you boiled a fine piece of beef in pure water you obtained on one hand a piece of meat without nutritive properties and on the other a liquid made toxic by the purins it contained. We can once more enjoy a real soup with scientific satisfaction.

In the light of facts (which after all is said still have some value) and with the exercise of some judgment, we should be able to avoid these perpetual variations which do not increase our prestige and seem to be based on the search for novelty at any price.



## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### IS IT SCIENTIFIC TO GIVE VACCINES ON A CLINICAL DIAGNOSIS?

By G. H. SHERMAN, M. D., Detroit, Mich.

Vaccine therapy rests on the principle of hastening immunization during the course of an infection. That inoculation of killed organisms corresponding to the ones causing the infection accomplish this is no longer seriously questioned. The question is: Can a diagnosis be made from clinical indications that is sufficiently accurate for vaccine administration. Different pathogenic organisms often cause pathological conditions that are very similar and, furthermore, more frequently several different varieties of germs are prominent factors in the infective process. To institute treatment that is directed towards definite infecting organisms without first ascertaining what variety of organisms are present by bacterial examination, does seem out of place, but to proceed scientifically it is necessary to apply all available knowledge to the best advantage.

A most important factor in vaccine therapy is early administration. Friedlander says: "It is a rule of all vaccine therapy that its success is in direct proportion to the time of its administration. The earlier the vaccine can be given in any infection, the better the results following its use." In virulent acute infections like pneumonia, puerperal sepsis, erysipelas, infected wounds, even a half day's delay in giving vaccines often mitigates towards prolonging the disease and sometimes may be the direct cause of a fatal termination. Under such circumstances, delay in treatment, for the sake of making a bacterial diagnosis can certainly not be of scientific interest to the patient. The principal infecting organisms in most infectious diseases are known. In pneumonia we have principally the pneumococcus to deal with, while the streptococcus

is the most likely complicating factor. Then why not give a combined pneumococcus, streptococcus vaccine at once? It does not make our scientific knowledge any better to know that the pneumococcus is causing the trouble in the particular case under treatment than to know that this is practically always the dangerous invader in this disease. In puerperal sepsis, we are presented with practically the same condition. Here the streptococcus is the dangerous infecter. It is true that other less virulent infecting organisms may cause a rise of temperature in the puerperal state, but is it scientific to withhold efficient specific treatment until the presence of a streptococcus is definitely established while such delay may do irreparable damage to the patient? The giving of a therapeutic dose of streptococcus vaccine in such a case is of inestimable value in checking the development if a streptococcus infection exist. The fact that other infecting organisms are commonly present in such cases argues in favor of using a mixed vaccine, at least until bacterial examinations have demonstrated that not all the organisms represented in the vaccine are present in the infection.

In infected wounds clinical indications are usually very clear as to whether a streptococcus invasion is present. Where the inflammation has a tendency to spread rapidly, leaving red lymphatic streaks, streptococci are present. In these cases staphylococci are so frequently complicating factors that a combined strepto-staphylo vaccine is indicated and should be used. In accidental wounds, the possibility of tetanus infection should always be kept in mind and taken care of with a prophylactic dose of antitetanic serum.

The clinical symptoms of erysipelas are sufficiently distinctive that vaccine therapy may be successfully applied without a bacterial diagnosis.

Where we have infections of deep-seated organs, our general knowledge as to the usual infecting organisms in such cases makes the application of a corresponding vaccine a most rational procedure. Here it is evidently more scientific to institute efficient bacterin treatment and cure the patient, than to follow out the expectant plan until a positive bacterial diagnosis can be made, after operative interference has become necessary.

Infections of the respiratory tract are very amenable to vaccine therapy and are so prevalent that every practitioner meets with them daily. Here mixed infections are common with the pneumococcus

and streptococcus (outside of diphtheria infections) as the most constant dangerous invaders. The recognition of this fact constitutes scientific knowledge and a correspondingly combined vaccine may accordingly be consistently given on a clinical diagnosis. In these cases cultures from inflamed mucous membrane or sputum may be readily procured and naturally where facilities are at hand the clinical diagnosis should be verified by culture and microscopic examination.

No one would consider it unscientific to give diphtheria anti-toxin where clinical symptoms would indicate a probable diphtheria. Why? Because experience shows that there is greater danger in postponing treatment while waiting for a positive bacterial diagnosis than the possible danger of giving the serum where it is not needed, although some fatal anaphylactic shocks have followed its use.

If there were even a similar danger from the use of vaccine there would be some excuse for objecting to vaccine inoculations on a clinical diagnosis, but anaphylactic shocks or other reactions of serious nature never follow their use. This is equally true of mixed vaccines. There is no evidence that any harm has ever come where the vaccine used contained a larger variety of organisms than were present in the infection, nor were the therapeutic results less pronounced on account of the larger variety of organisms present. Scientific methods for doing things simply consist in utilizing all the available knowledge to the best advantage. Practical experience teaches that vaccines can, in acute infections, be given most effectively on a clinical diagnosis because their early administration in these cases is of the greatest importance.

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## THE OPERATIVE CURE OF PRURITUS ANI AND VULVÆ.

By CARROLL W. ALLEN, M. D., New Orleans.

I wish to present an operation for the relief of Pruritus Ani and Vulvæ, that distressing, tantalizing and torturing condition for which the remedies suggested have been legion and the results usually negative.

Within the last few years some encouragement has been found in the investigations of Murray, Hirschman, Ward and others who have been able to incriminate the streptococcus fecalis as a causative

factor. My own investigations in this field having preceded the published reports of these gentlemen and having yielded prompt, complete and permanent relief by a comparatively simple operative procedure, I have had no occasion to resort to other methods; I am however, inclined to believe that they are correct in their conclusions for the following reasons:

Reflexes play but a minor role, if any, in the production of this condition; most often there is no other recognizable pathology, and hemorrhoids, ulcers, fissures, fistulæ, lacerations of cervix and perineum, etc., when relieved usually fail to benefit the condition. If a reflex, it should be limited to the distribution of some nerve and not to an anatomic area.

I have located and injected the pudic nerve and divided the inferior pudendal nerve without any apparent relief. Among the other measures which I attempted were alcohol and quinin injections which proved disappointing.

The proposed operation has in view the separation of the skin from the underlying tissue thus dividing all nerves which reach the affected parts, rendering them anesthetic, and preventing the skin from immediately healing to the underlying tissues by packing, which is kept up until a firm bed of granulation has formed, which usually requires about one week, when the packing is discontinued and the skin allowed to fall back in place where it soon is again firmly united, leaving an anesthetic area which nearly equals the extent of the undermined area. This anesthetic area is not complained of but is usually a quite welcome change. It gradually diminishes in size with the return of normal sensation after a few months and has in my experience not been followed by a return of the pruritus.

The operation upon the anal region is the simpler. The area involved must first be accurately determined; it is usually quite symmetrical and uniform on both sides. A series of incisions are now made beginning at the anal margin and continued outward to about one-half inch beyond the affected area, which rarely exceeds two inches. A series of these incisions are made about one inch apart at their peripheral extremities until the entire perineal region has been covered.

These skin strips are now dissected up, preferably with a scalpel, except at their two ends which are left attached. In separating the skin from the subcutaneous tissues but a small margin of tissue



is left attached to its under surface to insure a sufficient circulation to prevent sloughing. As the pruritic area rarely involves the mucous surfaces the incisions need not invade them, and in a few cases where the vaginal mucosa seemed to have been involved it cleared up with the relief of the external parts. The operation upon the vaginal outlet is performed in the same general way as upon the anal region and should need no special description. After dissecting up the skin flaps the space beneath is packed with iodoform gauze. Frequent Sitz baths with a liberal supply of soap has always been insisted upon as an after treatment. They keep the parts cleansed and are more effective and comfortable than irrigations. The packs may occasionally need changing but often remain the full time, about one week. After the packs are removed the parts quickly unite. The total disability is about two weeks.

In considering this operation in the light of the recent bacteriological investigations of the streptococcus fecalis it is possible that the iodoform plays an antiseptic role here, or, more likely the soap which has been proven a quite active germicide and in the exposed condition of the tissues may eradicate the infection if such is the cause, or, should we take the other view that the prolonged anesthesia of the parts effectively breaks the itching and scratching habit; the fact is that the cases get well and as far as I have been able to follow them remain well.

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## THE ROLE OF THE PHYSICIAN IN PHYSICAL EDUCATION.

By C. M. MENVILLE, M. D., Health Officer, Houma, La.

Among the different branches of Social Hygiene, physical education holds without doubt the most important place.

In order to rear our children to be strong, resistant and energetic, we must develop them from their tender age along different lines at our command. These means are numerous, but it is necessary to mention the principal ones only: gymnasium, sport, dancing, games, walking, running, swimming, horse-riding, rowing, singing and deep breathing, of course calisthenics comprise some of these movements; in a word all acts of our human life, where movement forms the base of exercises. "Movement," alone, if rationally applied is able to create in our organism, strength, will power and force of character; it gives agility and ability to all persons who make a constant conservative use of it. "Movement is Life," is a

justified maxim. But, if movement is necessary to create a healthy soul in a healthy body, "Mens sana in corpore sano," the excess of exercise can also be detrimental.

Fatigue brought by a consequence of irrational acts, brings about as grave consequence as would too much brain work. It is then essential to select proper exercises and to dish them out according to the constitution and the age of each individual; one must learn to avoid giving to a sickly or pathological child, the fatigue occasioned by violent exercises. Still a majority of our pedagogues and gymnastic directors, seem to have quite the opposite view of the above; many of them think that physical exercise has a tendency to rest the mind. This misplaced opinion has been so generally accepted that even today in some schools, teachers will prescribe gymnasium or some intensified sport to rest the child who has been fatigued by his studies.

The physiologists have nevertheless, in repeated instances, demonstrated that all muscular activities are transmitted through centre pedal channels (as do sensorial impressions) to the nerve centers and finally end by giving fatigue similar to that produced by intellectual work. We therefore can see that if the child is already overworked mentally and is given bodily exercise as a rest, he will eventually be killed as readily as if he were given daily doses of a slow but deadly poison. Is it not a known fact that muscular lassitude lowers mental activity? It is then of prime importance to know how and when to utilize with profit each of these recreative exercises. One must be able to select the kind of play and the best time suited for the physical development of each separate individual. The natural deduction brings us to this: If we wish to obtain the best results from physical education, we should place it under the supervision of one who is best adapted by training and education to handle it, and that is the Physician who has or should have the art to heal the sick and also that of prolonging good health to those who are disposed to keep well. He, alone, should be qualified to make a justifiable application of recreative sport of any kind. Some may need one kind at a certain time, others may need other kinds at other times and some may need complete rest for some time.. It is to him therefore that the direction of such exercises should be confided and not to the empirics or non-qualified who have no knowledge of the physiological modifications of childhood, of youth and even of adults.

Physical directors are no doubt fine dispensators of physical recreation, but they should act like the druggist; they should simply fill the prescription of the physician for each and every case under their care. Who is or should be the best judge of the different systems of our organism and of its educating action on psychomotor centers of individuals but the physician who understands the makeup of our frame and comprehends the working of that frame either in health or in sickness? To him devolves the responsibility of knowing the bodily action in general and applying such physical treatment to keep nature where it is weak or wanting. Any indifference or ignorance on his part can spell nothing but sinful deficiency.

If there is any sphere where the physician should have a controlling voice, it is that of social hygiene in general and of physical education in particular, for it is impossible to conceive a healthy condition of the family without his domain. But he cannot do this alone. He needs the physical director, the engineer, the architect, the conductor, the workman, etc., in order to realize the hygienic condition of our lives. They all must contribute in the building up of the social arch, but the physician shall be the key-stone of that arch. He shall devise, prescribe and superintend the necessary outlines that go to make physical education; he must supervise the manifestations of growth, the vicious habits of childhood, the physio-pathological phenomena of puberty, the different phases of nervous debility. Oh! How wise his supervision in all these, for how much wrong can be wrought by the intemperate application of unwise exercises which may have not only grave but irreparable consequences. To his generalship then must we look for healthier, stronger, well balanced children, who are called to make a better generation.

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### TYPHOID FEVER.

(From the Bulletin de l'Académie de Médecine, Paris.)

By LODILLA AMBROSE, Ph. M., New Orleans.

Minet<sup>1</sup> during six months in a typhoid hospital installed just behind the lines observed a certain number of pulmonary localizations, some were caused by common microbes, others by the different varieties of paratyphoid bacilli. He found the latter in seven cases. Clinically, he observed simple bronchitis, acute pulmonary congestion, chronic pulmonary congestion, congestion of the

apex simulating tuberculosis. The bacteriologic tests included direct examination of the fresh sputa and of stained specimens, and culture (technic for isolating paratyphoid bacillus described).

Tarassévitch,<sup>2</sup> of Moscow, reported hostility to antityphoid vaccination before the war. The Société Pirogoff studied the question (December, 1914), but did not insist on compulsory vaccination. The general union of the Zemstvos (May, 1915), impressed by the good results obtained in France and England as well as in the armies of the enemy, decided that it was urgent to apply antityphoid vaccination not only to all the Russian army but also to a certain portion of the civilian population. After active propaganda it was made obligatory in the army. Several million soldiers at the front have been vaccinated, and up to February, 1916, more than 20,000 litres of vaccines had been used. April, 1914, the monovalent English vaccine was adopted; later the congress of bacteriologists convoked on the initiative of the union of Zemstvos decided to use only vaccines prepared by methods approaching those of the Pasteur Institute. All the vaccines are controlled, and the reactions of vaccines from the different sources are studied carefully. The French technic of injection is used. The general reaction is *nil* or feeble in 90 to 95 per cent. of the cases. The results are unquestionably favorable. Before vaccination typhoid and paratyphoid fevers constituted 50 per cent. of the infectious diseases. More than 500,000 soldiers have been vaccinated against cholera. Experiments are in progress with mixed vaccination for small-pox, cholera and typhoid, that is, on the same day. Near Moscow 25,000 men were so vaccinated, and moderate and strong reactions rarely exceeded 5 per cent. This triple vaccination is under consideration for the entire Russian army.

Pétrovich<sup>3</sup> reported on antityphoid bacteriotherapy on the basis of 2,270 cases so treated and 1,030 treated symptomatically; in the former group the mortality was 2.7 per cent. and that without cold baths, in the latter it was 12.8 per cent. Weak doses are favored, and in severe cases are diminished, not increased. With complications (nephritis, myocarditis) and insufficient elimination the vaccine may be used in reduced doses. Uncertain and unfavorable results reported in the journals are attributed to late treatment of much weakened patients. Two rules for this bacteriotherapy are laid down:

- “1. To avoid every pronounced reaction, local or general.



“2. To base it on the progress in the improvement of the general condition of the patient, and especially on the lowering of the temperature, meanwhile giving attention to the functions of the liver, of the kidneys, of the skin, of the respiratory organs, and of the intestines, in such manner as to take account of the work of destruction and of elimination of toxins by these organs.”

Trillat<sup>4</sup> has studied the mechanism of the propagation of typhoid by milk. Milk can be planted with typhoid directly by persons bearing the germs, or indirectly by water used to dilute milk or for washing milk utensils. Milk is second only to drinking water as a conveyor of this infection. It is an extraordinarily favorable medium for the proliferation of the typhoid bacillus, and water apparently pure may contain bacilli enough to produce growth in milk. Experiments were made with sterilized milk and with milk invaded by other germs than typhoid. In the latter case if the typhoid planting was minute, the bacillus disappeared. The bactericidal effect of lactic acid increases with time. The explosive development of the typhoid bacillus takes place in germ-free milk. The rapidity of its growth varies with the character of the other germs in the milk. Humidity, barometric pressure and temperature affect this growth indirectly. Invasion of milk by the typhoid bacillus does not alter its appearance or taste. Cases of typhoid in the personnel of a dairy or in its vicinity necessitate redoubled surveillance.

Chantemesse<sup>5</sup> in collaboration with Grimberg presented a paper with charts and illustrations on intricated typhoid fevers. Full details are given regarding his technic for separating the different typhoid germs. In his conclusions Chantemesse says:

“1. Common typhoid fever is not always due to the pure and simple invasion of the bacillus of Eberth. Although this germ constitutes its most important and most serious cause, often there intervenes at the onset, or in the course of the evolution of the disease, a concomitant infection of the paratyphoids A and B. With the aid of an appropriate technic, the blood culture reveals the presence of several typhoid germs and the examination of the serum that of different specific agglutinins due to these germs and distinct from the group co-agglutinins.

“2. The comparison of the curve of the temperature of the patients and the curves of the specific agglutinins of their blood shows the influence exerted on the thermic evolution by the in-

vasion of new typhoid germs. With this secondary invasion may often be connected the thermic oscillations called reiterations, relapses, amphibolic stage, etc.

"3. The recovery from common typhoid fever ordinarily confers an anti-Eberthian immunity which is extended to one paratyphoid or to both. On the contrary, vaccination against solely the bacillus of Eberth does not entail so general an immunity. The reason of this fact is found probably in the plurispecificity of ordinary typhoid as opposed to the monospecificity of the anti-Eberthian vaccination.

"4. . . . According to the facts which we report, it is seen that this method [mixed vaccination devised by Castellani in Ceylon ten years ago] is quite legitimate. Just as the human organism adapts itself to tolerating the triple infection of the typhoid germs, it tolerates the triple antityphoid vaccination.

"5. The blood culture practised in the course of typhoid fever giving positive results in only about half of the cases, the procedure of choice for the diagnosis of this disease is the search for and watching of the curve of the agglutinins *by the macroscopic and mensurative method with the aid of emulsions derived from the typhoid and paratyphoid bacilli*. This procedure is simple and sure.

"6. The presence in the blood of a patient of an agglutinin due to a previous typhoid fever, or to a previous preventive vaccination, offers no obstacle to the diagnosis by the use of this method, for the curve of such an agglutinin remains invariable, while the curve of the agglutinin of a disease in evolution undergoes the ordinary phases of ascent and of descent.

"7. When the diagnosis of a plurispecific typhoid infection is declared, the dilute vaccine used in the treatment of this disease ought to be mixed."

Étienne<sup>6</sup> treated in his services in 1914-15 about 200 typhoid patients, of this total 12 showed an abortive type of the disease. Of these 12, 8 had been treated very early by serum (obtained from Rodet), and 4 had been vaccinated. He submitted curves and statements to show a similarity in the evolution of the disease under these two conditions, and claimed from this similarity a proof of the analogous specific action of the two processes.

Chantemesse<sup>7</sup> referred to his earlier reports on optional vaccination against typhoid as introduced in the French navy, April,

1912, the results having been favorable. To the end of 1915 the heated vaccine prepared with the pure typhoid bacillus was used; since then it has been prepared with the bacilli of typhoid and paratyphoid A and B. The vaccine is injected in increasing doses in four weekly punctures, in such manner as to have the patient absorb five and a half milliards of dead bacilli. Vaccination became compulsory in the navy, March, 1915. Enough vaccine was provided to vaccinate about 125,000 men. He estimated that 80,000 were actually vaccinated, and 60,000 were not. From the records of the marine hospitals, August 1, 1914, to April 1, 1916, he produced statistics: Cases of typhoid and paratyphoid among non-vaccinated men, 525 with 77 deaths, a mortality of 14 per cent.; cases of typhoid and paratyphoid among men vaccinated either completely or incompletely, 136 with 10 deaths, a mortality of 7 per cent. Of these 10 deaths, 3 were cases of paratyphoid B, 2 were cases of typhoid supervening during the process of immunization, 4 were cases of typhoid supervening in persons incompletely vaccinated but with staphylococcus found in meninges. He claimed that the disadvantages and dangers resulting from this vaccination in the four-year period were practically *nil*.

The last half of his article consists of blank pages with the words, "Supprimé par la censure."

Daumézou<sup>8</sup> reported in detail observations which tended to show that the "typhoid agglutinins can irregularly pass into the cavity of the meninges in case of certain cerebro-spinal meningites due to the meningococcus of Weichselbaum."

*See also* Rodet, Antityphoid Serotherapy, this JOURNAL.

1. Minet, Jean. Congestions pulmonaires à bacilles paratyphiques. 3. s., *ixxv*, 196-198.
2. Tarassévitch, L. A. Vaccinations antityphoïdiques dans l'armée russe. 3. s., *ixxv*, 579-582.
3. Pérovitch. Recherches sur la bactériothérapie de la fièvre typhoïde; au cours de la campagne récente en Serbie. 3. s., *lxxv*, 725-727. *See also* Pérovitch. Quelques considérations sur la prophylaxie et le traitement spécifique de la fièvre typhoïde, à l'occasion d'une épidémie survenue au cours de la campagne actuelle de l'armée serbe. Bull. Acad. de méd., Paris, 1913, 3. s., *ixix*, 305-307. Pérovitch. Sur le traitement de la fièvre typhoïde par l'homosérothérapie dans l'armée serbe. Bull. Acad. de méd., Paris, 1915, *lxxiv*, 83-86.
4. Trillat, A. Nouvelles observations sur le mécanisme de la propagation de la fièvre typhoïde par le lait. 3. s., *lxxv*, 738-742.
5. Chantemesse, A., and Grimberg, A. Les fièvres typhoïdes intriquées. 3. s., *lxxv*, 744-758.
6. Étienne, G. Similitude d'évolution de la fièvre typhoïde sous l'action de la sérothérapie et de la vaccination. 3. s., *lxxvi*, 30-34.
7. Chantemesse, A. Résultats de la vaccination antityphoïdique dans la Marine française. 3. s., *lxxvi*, 140-144.
8. Daumézou, F. G. Transsudations des agglutinines typhiques dans le liquide céphalo-rachidien de l'homme. 3. s., *lxxvi*, 101-103. *See also* Daumézou, F. G. Sur la flore typhique et paratyphique du liquide céphalo-rachidien. Bull. Acad. de méd., Paris, 1915, 3. s., *lxxiv*, 123-125.

## CLINICAL REPORT.

### FIVE HUNDRED APPENDECTOMIES.

By DR. ELLIOTT KIBLINGER and DR. ADA KIBLINGER, Marksville, La.

This report covers cases of appendicitis of the simple acute form to those with perforation and its complications, at the Kiblinger Sanitarium.

The essential points which we wish to bring out will be classed under the following headings.

1st. The order in which the symptoms occur.

2nd. Some rare complications which we encountered and which had an etiological significance.

3rd. Our method of handling normal and certain complicated cases.

4th. How our uncomplicated cases progressed.

In the careful study of these five hundred cases we found, with the exceptions noted, that the regular symptoms which always occur in appendicitis, namely: Pain, nausea and vomiting, tenderness and rigidity, fever and leukocytosis, invariably occur in the order here stated. This regular sequence of symptoms was first stressed by the late and lamented Dr. Murphy of Chicago. It is valuable in that it assists one in making a diagnosis, for as Dr. Murphy says, and which our own experience corroborates, if the symptoms occur in any other order the probabilities are that we are not dealing with appendicitis. The one exception which we encountered was in those cases where the intestinal tube was filled with *ascarides lumbricoides*. On account of the prevalence of this intestinal parasite in our section of country we, as a routine measure, kept this in mind. The toxemia produced by *ascarides lumbricoides* is so interesting that we have decided to reserve this data for a future report. The citing of one such case will serve as an example of what one may find upon examination and also what an exploratory incision shows. Case No. 470 female, age 13 years, was referred to the sanitarium by a confrere with a diagnosis of perforated appendicitis and general peritonitis. Temperature 105°; glassy eyes, pinched expression. Very marked distention of abdomen. Under ether we discovered two separate masses within the abdomen but the one under McBurney's point appeared to be more tender and evidenced more heat and redness. The entire surface



of the abdomen was tympanitic and swollen. After opening the abdomen we found a ruptured appendix in a walled off abscess in which was one worm. The other mass proved to be a bunch of worms occluding the entire lumen of the bowel and thus producing an obstruction. This condition was met by doing a colocolotomy. Now we wish to discuss the round worm and its toxins as an etiological factor in appendicitis. That this parasite secretes a toxin, its effect upon the system being manifested by abdominal pain, swelling, anemia, and high fever (105-107) is beyond discussion. Dr. Elliott Kiblinger upon one occasion made the error of operating for appendicitis upon a case of *ascarides lumbricoides* in which the clinical picture of a perfect general peritonitis was present. In this case he was fortified by an agreement as to the diagnosis by consultants.

During the quiescent period when the patient is not suffering with any localized pain, we have found the following maneuver assists us in arriving at a diagnosis. If pressure be made over first the transverse colon then the ascending colon,—against the current,—any gas in the colon will by this means be forced into the cecum and cause pain.

Now we will take up our method of handling simple acute cases and also one or two complications. In simple acute appendicitis, thanks to an, I might say, uncanny sense of touch which the junior surgeon of our staff has perfected, we are enabled to remove an unruptured acutely inflamed appendix through an incision of not over one and one-half inches and to complete the operation in from seven to ten minutes. This is done dexterously and without trauma which assures us a rapid and easy convalescence marked by freedom of symptoms. In complicated cases where the appendix is bound down in a bed of adhesions, we save time and eliminate trauma by first amputating the appendix at its base and then freeing the organ to its tip. This method saves time, prevents trauma, and makes for simplicity. In all our simple acute cases our patients are allowed to sit up as soon as the bowels move which generally is within three days.

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**MISCELLANEOUS.****STATEMENT FROM THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER.**

By HARVEY R. GAYLORD, Buffalo, N. Y.

I am very glad to take this opportunity both in the name of the Institute for the Study of Malignant Disease, the State of New York and the American Society for the Control of Cancer which supported this purchase to make a statement on the purchase of two and a quarter grams of radium for which \$225,000 was appropriated, as announced by Gov. Smith recently.

The experiment in state ownership of a therapeutic agent, as exemplified in the purchase of this radium for social utility will have a far reaching effect. This is a development of state medicine to which no one can object and Governor Smith deserves the thanks of the state for what he did.

Any citizen of the United States may avail himself gratuitously after October 15th of treatment with the two and one quarter grams valued at \$225,000 recently purchased by New York State and the first gram of which was delivered by the Radio Chemical Corporation of New York last week. Preference, however, will be given to citizens of New York State.

The first gram is now in the vaults of the Institute at Buffalo and the appliances necessary for its use in the treatment of cancer are now in course of construction. The engagement of a competent physicist to work with this radium is also announced. The radium we are using is an American product, mined in Colorado, brought 2900 miles across the continent in the form of 125 tons of carnotite ore to the extraction plant at Orange, N. J., where it was reduced by fractional crystallization to its present state.

The first purchase of radium by any state, marks a step in the health activities of an American Commonwealth. Up to the present we have had no therapeutic agents, so expensive that they could not be afforded by the average practitioner. In the case of radium that condition arises. The unit for efficient use costs not less than \$12,000 and represents 100 milligrams. A gram is worth \$120,000. The greater the quantity in an installation the more efficient it is, and the less it costs per treatment. New York State has met this condition by purchasing an amount available for all its citizens.

The value of radium has already arrived at a stage where states, and if necessary the government, should make radium available for cancer treatment, gratuitously and beyond the realm of financial limitations. The advent of radium as a therapeutic measure is the most important forward step in the treatment of cancer.

It is not surprising that when radium first made its appearance over-optimistic claims for its use and hope of its utility should have occurred. But that time is now past. Radium has been made available in smaller and larger amounts to all the important centers of cancer research in this country, with the result that not alone has new knowledge of this agent been greatly advanced by the technique of its use as well as its limitations have been more definitely defined. The last six years have marked steady progress in its application, and means of more scientifically and more efficaciously employing it have been developed.

The State Institute as a result of carefully controlled scientific experiment in its hospital felt that the time had come when the State of New York should logically provide an adequate amount of radium for the Institute on the basis that its value is so definitely demonstrated that it should be made available without cost to the citizens of the State and that the opportunities for research should now be extended along practical lines. The State Institute has had since 1914 an amount of radium sufficient for scientific study. Private philanthropy has given the Memorial Hospital in New York City a large amount of radium for scientific investigation and practical application for the past four years. The Cancer Research Commission of Harvard University has also had an adequate working supply. The advances made in these and other quarters has steadily strengthened the confidence in the use of this agent and all of these centers are now seeking means to increase their supply.

The State of New York, which in 1898 took the lead by founding the first modern State cancer research institute in this country, should properly be made the first state to appropriate the necessary funds for the purchase of a sufficient amount of radium for the use of its citizens having available for this purpose a center of cancer knowledge and fully equipped scientific research laboratories where its use can be made immediately effective, and from which scientific progress can be confidently anticipated.

The usefulness of radium in the treatment of neoplasms is still

in its infancy, but there are already certain kinds of cancer in which its use offers advantages and the results obtained are an improvement upon any means we have heretofore possessed. It must, however, be remembered that our main reliance in the treatment of cancer is surgery but radium in combination with surgery, frequently greatly improves the prospective cure.

The scientific development of the last two years in the use of radium, largely through the work of Professor William Duane of Harvard University, made available a means of using radium which has immensely strengthened its usefulness. This method is the use of the emanation of radium in place of the application of radium itself. This method is only available when you have at least one gram.

Cancer today is one of the most important diseases in the United States. It increases 25 per cent every ten years. In the United States 90,000 deaths occur yearly from it, being of equal importance to tuberculosis. In New York State about 8000 deaths occur yearly.

The purchase of the radium has other significance than merely its use for the treatment of cancer. It gives an opportunity for research and its use under scientific conditions is sure to increase our knowledge of cancer. While surgery still remains our main reliance in the fight against cancer we can only hope greatly to improve the results of surgery by bringing the patient to surgical treatment at the earliest possible moment. This can only be accomplished by the diffusion of knowledge among the laity of the first beginnings of cancer. It is with such work as this, that the Society for the Control of Cancer has particularly charged itself. It is felt by the Society that the advent of an alternative will overcome the reluctance of many cases to present themselves to their physicians. The Society represents 900 physicians and laymen and looks with great interest at the purchase and congratulates New York upon the step it has taken.

The purchase of this radium by an American Commonwealth from an American Company which has mined its ore in the State of Colorado, will bring still further to the fore the pre-eminence of America in the treatment of cancer. Buffalo will become a radium center. While Europe, through Madam Curie, first made the precious element known to the world, the United States has developed both the ore, its extraction and its use as a therapeutic



agent. It is today in the forefront of treatment of cancer. This purchase may have a tremendous effect upon further progress in this direction.

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## **THE UNIVERSITY OF WARSAW RESEARCH LABORATORY.**

Thanks to the American Red Cross, Warsaw has a new medical laboratory. It is the finest in Poland, and one of the most complete and up-to-date in the world. The equipment, which is new throughout, was transported across the Atlantic and half Europe, complete from the simplest phial to the largest and most expensive instruments, including a complete research microscope with a magnifying power as great as any in the world.

The unloading and unpacking of the large shipments of laboratory material was not accomplished without difficulty. At first refugees were employed, but they were found in many cases to be so physically weak from prolonged underfeeding that the Red Cross doctors themselves finally rolled up their sleeves and helped to unload the heavy freight.

No gift of the American people to suffering Poland is more valuable than this great hospital laboratory, which is the eighth laboratory opened by the Red Cross. In all these laboratories American chemical stains are used instead of the German chemicals with which it used to be thought that no other product could compete. American peptone is likewise used exclusively in fermentation processes, replacing the German, formerly the world standard. The services of these laboratories are greatly adding to the efficiency of the fight being made in Poland against the spread of typhus and cholera, both of which are still dangerously prevalent. The new laboratory, under the direction of Major Bruce Mohler, of Fremont, Ohio, is in charge of Dr. Placida Gardner, of Los Angeles, with Dr. Gladys Vaughan, of Wolfeville, N. S., as chief bacteriologist.

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## **MUTUAL APPRECIATION.**

Not long ago one of our confreres, having rendered some special service to a young lady, in due course of time sent her his bill.

He was surprised and still more gratified to receive, enclosed with a check in payment of his fee, the following:

Your bill for repairing my eyes  
Seems most *microscopic* in size.  
With charges like these,  
Next winter you'll freeze  
And the *rest of your life* Hooverize!

In due time, together with the receipt, the doctor, not to be outdone, returned this:

Of letters like yours there are few:  
Growls and "kicks" are the doctor's just due.  
For such notes as you write,  
I would sit up all night  
"Fixing" eyes till old chanticleer crew!

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## BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Secy-Treas.

The Louisiana State Medical Society is now enjoying a membership of over eleven-hundred,—the highest since its organization, seventeen years ago. We are by no means satisfied by this showing, however, and trust that by the assistance of our Councilors and members we may be able to add many more desirable names to our rolls.

The Louisiana State Board of Medical Examiners reports a registration of approximately two-thousand and twenty-five Physicians and Surgeons in the State of Louisiana and it is our anticipation that many of these will signify their willingness to join the State organization before the termination of our Fiscal Year.

The American Medical Association, through its Council on Health and Public Instruction, recently requested the President of the Louisiana State Medical Society to appoint a committee on "Health Problems in Education", for our State, to co-operate with the State Board of Education. This committee has been appointed; the personnel is as follows:

Dr. A. A. Herold, Shreveport, La.

Dr. G. C. Antony, Alexandria, La.

Dr. A. L. Whitmire, New Orleans, La.

Dr. Hugh St. Martin, Houma, La.

Dr. S. L. White, Ruston, La.

The work to be assigned to this Committee is of great importance and I am sure great good will be accomplished through their endeavors in handling such propositions as may be confronted by them.

The Secretary-Treasurer has recently been notified of a proposed conference of the various State Secretaries to be held at the American Medical Association headquarters in Chicago, some time in the latter part of October or early in November. At this time various questions for the betterment of our State organization will be discussed. We are attempting to gather all the information possible which might improve our local and State organization. In order that your Secretary may be in a position to properly discuss such subjects at this conference, any suggestions or recommendations, pertaining thereto, will be greatly appreciated and valued.

At the last meeting of the Executive Committee of the Louisiana State Medical Society the President was empowered to appoint Fraternal Delegates to other State Medical Society meetings. Such appointments will be very shortly announced and we earnestly implore each appointee to attend, if possible, the respective State Meeting for which he is appointed. This is a very important function and will keep our State Organization in close touch with the progress of other State Medical Societies.

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## NEWS AND COMMENT

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RECIPROCATING STATES.—The Louisiana State Board of Medical Examiners announces the following states with which Louisiana, reciprocates: Alabama, Arkansas, California, Colorado, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia Wisconsin and Wyoming. A total of 35 states.

CIVIL SERVICE EXAMINATIONS.—The United States Civil Service Commission announces open competitive examinations for the following positions: Training Officer; Training Assistant; Placement Officer; Placement Assistant; District Medical Officer; Assistant Medical Officer, Federal Board for Vocational Education, Rehabilitation Division. Applicants should at once apply for Form 2118, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., or the Secretary of the United States Civil Service Board, Customhouse in their district. Applications should be properly executed, excluding the medical certificate, and must be filed with the Civil Service Commission, Washington, D. C., with the material required without delay.

NATIONAL RESEARCH COUNCIL CHAIRMEN.—The National Research Council, with headquarters at Washington, announces the election of the following chairmen of its various divisions for the year beginning July 1, 1920: Division of Foreign Relations, George E. Hale, Director, Mt. Wilson Observatory, Carnegie Institution of Washington; Government Division, Charles D. Walcott, Secretary of the Smithsonian Institution, and President of the National Academy of Sciences; Division of State Relations, John C. Merriam, Professor of Palaeontology, University of California and President-elect of the Carnegie Institution of Washington; Division of Educational Relations, Vernon Kellogg, Professor of Entomology, Stanford University and Permanent Secretary of the National Research Council; Division of Industrial Relations, Harrison E. Howe; Research Information Service, Robert M.



Yerkes; Division of Physical Sciences, Augustus Trowbridge, Professor of Physics, Princeton University; Division of Engineering, Comfort A. Adams, Lawrence Professor of Engineering, Harvard University; Division of Chemistry and Chemical Technology, Frederick G. Cottrell, Director of the Bureau of Mines; Division of Geology and Geography, E. B. Mathews, Professor of Minerology and Petrography, Johns Hopkins University; Division of Medical Sciences, George W. McCoy, Director of the U. S. Hygiene Laboratory since 1915; Division of Biology and Agriculture, C. E. McClung, Professor of Zoology, University of Pennsylvania; and Division of Anthropology and Psychology, Clark Wissler, Curator of Anthropology, American Museum of Natural History, New York.

**LEATHER SUBSTITUTES CAUSE ECZEMA EPIDEMIC.**—An epidemic of eczema and similar skin diseases has been discovered in Germany as a result of use of substitutes for leather in the perspiration band in hats. Oil cloth and other similar products have been used since leather became so scarce, and the results have been distressing.

**BETTER CONDITIONS FOR CHILDREN.**—In a pamphlet issued by the Children's Bureau of the United States Department of Labor is described a striking development in the movement to obtain better conditions for children. Ohio nine years ago appointed the first commission to study conditions surrounding children in the state, and to regulate and revise laws relating to its children. Since that time, sixteen other states and the District of Columbia have appointed similar commissions, and in almost two thirds of the states some definite action toward state legislation as it affects children has been taken. A carefully planned educational campaign, to safeguard the health, school attendance, regulation of employment, methods of dealing with delinquents and other important features has been carried on in almost all of these states.

**AMERICAN HOSPITAL ASSOCIATION TO MEET.**—On October 4-8 the American Hospital Association will hold its twenty-second annual conference in Montreal. Each of the sections has a special program, and the discussion will embrace hospital conditions existing in large and small hospitals. Through the cooperation of the Division of Venereal Diseases of the U. S. Public Health Service a model venereal disease clinic will be held. Arrangements for hotel accommodations may be made through Mr. H. E. Webster,

chairman of the local committee, Royal Victoria Hospital, Montreal. Communications for general information should be addressed to Dr. A. H. Warner, executive secretary of the association, 22 East Ontario Street, Chicago.

**TEXAS PUBLIC HEALTH ASSOCIATION ACTIVITIES.**—This association in a pamphlet distributed in all parts of the state recommends a thorough yearly physical examination for every person in the state, as an aid in the prevention and cure of tuberculosis. The pamphlet also tells the symptoms suggesting tuberculosis and the means of its prevention. The association during the year distributed 1,000,000 pieces of literature in its campaign to educate the people on this subject.

**RED CROSS MEMBERSHIP.**—Reports show that the United States leads the world in Red Cross members with more than 10,000,000 adults enrolled; Japan comes second with 1,900,000 members; Italy, third, with 300,000 and France, fourth, with 250,000 members. Membership figures for England, Canada and Australia were not available.

**AWARD OF FLORENCE NIGHTINGALE MEDAL.**—Miss Margaret Clotilde Macdonald, matron-in-chief of the Canadian Expeditionary Forces during the world war has been awarded the Florence Nightingale Medal. This is an international decoration which is awarded only to women whose work in the cause of humanity has been of paramount importance.

**INCREASE IN BIRTH RATE.**—According to statistics of the New York health department, the birth rate for the first seven months of this year is 22.34, as compared with 21.90 for the corresponding period in 1919. The infant mortality rate for the same period has declined from 92 in 1919 to 83 during the present year.

**RED CROSS WILL ESTABLISH PUBLIC HEALTH CHAIR.**—A chair of public health will be endowed by the Provincial Red Cross of Canada in the University of British Columbia, the Red Cross paying the salary of the professor for three years.

**MEETING SOUTHWESTERN MEDICAL ASSOCIATION.**—The fifteenth annual meeting of this association will be held at Wichita, Kans.,

November 22-24, under the presidency of Dr. E. E. Day, of Arkansas City, Kans. The association is composed of the states of Missouri, Kansas, Oklahoma, Arkansas and Texas.

**ALL-AMERICAN HEALTH CONFERENCE.**—On December 6-13 the first of a series of regional health conferences authorized by the International Health Conference will be held in Washington, D. C. It will be devoted to the consideration of venereal diseases. It is being organized under the combined auspices of the United States Interdepartmental Social Hygiene Board, the United States Public Health Service, the American Red Cross and the American Social Hygiene Association. There will be in attendance prominent health officers and sociologists from all parts of the North and South America. The conference will be under the presidency of Prof. Wm. H. Welch of Johns Hopkins University.

**FORMER BASE HOSPITAL BURNED.**—On September 2, twenty buildings of the former United States Base Hospital No. 1, now abandoned, in the Bronx were destroyed by fire. The amount of damage is estimated at \$20,000.

**TYPHUS MENACE.**—A plan to raise \$75,000,000, either by Congress or through private subscriptions, to send physicians and workers from the United States to join representatives of other countries in the fight against the world menace of typhus fever, will be laid before the Government by Dr. Harry Platz recently returned from Poland, where he has been making a study of conditions for the Joint Distribution Committee.

**ANNIVERSARY OF CANTON HOSPITAL.**—The eighty-fifth anniversary of the Canton Hospital, Canton, China, founded in 1835, will be celebrated this year. This is the oldest and one of the largest hospitals in the Orient, and is also the first missionary hospital in the world still in existence. More than two million patients have been treated in the hospital and its dispensaries during the 85 years of its existence. Modern medical education was introduced into China at this hospital. It is an international institution.

**JOHN B. MURPHY MEMORIAL.**—Plans are under consideration to erect a memorial to the late John B. Murphy, of Chicago. It will be in the form of the John B. Murphy Memorial Hall of the Ameri-

can College of Surgeons, and will be erected in Chicago at an estimated cost of \$500,000. It is proposed to have the building serve as a meeting place for medical societies, and to maintain there a pantheon of American medicine and surgery. Subscriptions to raise the amount are being undertaken by the John B. Murphy Memorial Association. One hundred thousand dollars have been pledged, provided the balance of the sum is raised.

DR. BIGGS HONORED.—Harvard University has conferred the honorary degree of Doctor of Science upon Dr. Herman M. Biggs, health commissioner of New York State.

GIFT TO AMERICAN SURGEONS.—Word has been received from London that the American College of Surgeons (which includes Canada) will soon be honored by a gift to be presented by British surgeons. It is intended as a remembrance of the work done in cooperation during the war, by British and American surgeons. It will be in the form of a silver gilt mace, the work of Mr. Omar Ramsden, and was suggested by Sir Berkeley Moynihan, working in connection with Sir Anthony Bowlby and Sir D'Arcy Power. The design includes maple leaves and American eagles, the badges of the British and American Army Medical Corps, the serpents of Esculapius, and the name of Philip Syng Physick (1768-1837) is introduced. The inscription reads: "From the consulting surgeons of the British Armies to the American College of Surgeons in memory of mutual work and good fellowship in the Great War."

STATE SELLS LEPERS' HOME.—The sale of the Louisiana leprosarium located at Carrville, La., to the U. S. Government, has been authorized by the state legislature; it will be used as a national leprosarium. The price paid was \$35,000. By the terms of the sale, the lepers, now inmates of the institution, are taken over by the U. S. Public Health Service.

BRAZIL PRESENTS HOSPITAL TO FRANCE.—The chamber deputies of Brazil recently voted an appropriation of 1,133,000 francs for the Brazilian Hospital at Paris to equip it to serve as a surgical service for the medical faculty.

MEETING AMERICAN CHILD HYGIENE ASSOCIATION.—The meeting of this association will take place in St. Louis, October 11-13.  
"15."



This will be the first meeting of this association held in the Southwest, and will be of great value to physicians interested in obstetrics, pediatrics and public health.

**SOUTHERN MEDICAL ASSOCIATION MEETING.**—The annual meeting of this association will be held in Louisville, Ky., November 15-18. It is being planned to make the coming meeting the largest in the history of the association, and the officers advise that hotel reservations should be made early, in order that all may be accommodated.

**NEW YORK CITY TAKES STRAUSS MILK STATION.**—Health Commissioner Royal S. Coupland of New York City on Sept. 1, formally accepted in behalf of the city the Nathan Strauss milk stations and laboratory, which this philanthropist has maintained since 1892, and which was recently presented to the city with the proviso that it assume the responsibility of maintaining them.

**MEETING OF ANESTHETISTS.**—The National Anesthesia Research Society will hold its first annual meeting in Pittsburgh, October 4 to 8. The meeting will be in conjunction with the Interstate Anesthetists' Society, the Western Pennsylvania Odontological Society and the Medical Society of the State of Pennsylvania. Headquarters will be at the William Penn Hotel. Prizes aggregating \$200 for the best papers on anesthesia will be awarded.

**THE AMERICAN RELIEF COMMITTEE** for sufferers in Austria—261 Madison Avenue, New York, of which Hon. Frederic Courtland Penfield, late American Ambassador to Austria-Hungary is Honorary Chairman, has created a special fund for the relief of destitute Viennese physicians and surgeons. Contributions may be made to Alvin W. Krech, President, Equitable Trust Company 37 Wall Street, New York City, Treasurer of the Committee.

**THE SIXTH CONGRESS OF FRENCH-SPEAKING PHYSICIANS** of North America was held at Quebec on September 9, 10 and 11 under the presidency of Dr. Arthur Rousseau. The topics discussed at the general sessions were: the nephrites, venereal diseases, the treatment of wounds and accidents of labor.

Receptions were tendered by the Lieutenant Governor, Laval

University, and the president of the Congress. Clinics were held at the various hospitals. A dinner was given at the Chateau Frontenac on the second evening and on the last evening at 8 o'clock there was an excursion to the Ile d'Orleans.

RED CROSS TO SEND FEW NURSES OVERSEAS.—From now on, the Red Cross will send abroad only very few specially trained nurses with unusually high qualifications. The number of American Red Cross nurses in France and Italy is constantly decreasing. Poland is reporting as the only country to which additional nurses are being sent. Miss Alice Fitzgerald, recently appointed chief to the League of Red Cross Societies, gave the number of nurses in Europe on November 1st as follows: France, 30; Italy, 7; Palestine, 7; (approximately); Near East, 60; Balkans, 61; Russia proper, 2; Siberia, 139 to 160; Poland, 10; Greece and Serbia, 6; Persia, 1.

THE ROCKEFELLER FOUNDATION.—In co-operation with governments in many parts of the British Empire, has recognized the importance of aiding medical education in London and has selected the University College and Hospital School for its beneficence. It will provide an endowment to produce an annual income of 30,000 pounds towards an increased expenditure of 50,000 pounds for a new staff in anatomy, an increase in the staff of physicians and various other items throughout the institution. The building program will include an Institute of Anatomy, work upon which will be begun in a few months and be completed in 1923.

YELLOW FEVER DECREASING.—Recent reports from Vera Cruz show a decline in the number of yellow fever cases in that city. Surgeon Carl Michel, U. S. Public Health Service is in charge of the sanitary work, which is being carried out on a large scale and shows gratifying results. Dr. Hydeo Noguchi, of the Rockefeller Foundation, has left Mexico City for Vera Cruz, where he will aid in stamping out the epidemic.

NEURO-PSYCHIATRISTS ORGANIZE.—The Neuro-Psychiatric Association of Ontario, Canada, has been organized, and elected the following officers: president, Dr. Edward Ryan, Kingston; vice-president, Dr. Harry Clare, Toronto; secretary-treasurer, Dr. C. Crawford, Whitby. The association will extend its work to the

study of defective children, social welfare, care in the selection of immigrants, problems concerning the feeble-minded, psychoses and neuro-psychoses.

PLAGUE AT GALVESTON.—Surgeons of the United States Public Health Service report the eighth case of bubonic plague, with another case under observation.

DEATH OF PROFESSOR GUYON.—News has been received of the recent death of Professor Jean Casimir Felix Guyon, professor of genito-urinary surgery at the Hospital Necker, Paris, and for many years editor, in connection with Lancereaux of *Annales des Maladies des Organes Genito-Urinaires*. He was a member of the Institute and of the Academy of Medicine.

PHYSICAL EDUCATION IN FRANCE.—The French Senate has passed a bill providing for compulsory physical education of children. Training will begin at the age of six and continue until their military training period.

PERSONALS.—The following doctors have returned from their vacations and resumed practice: George Tusson, W. F. Pettit, Geo. K. Pratt, Jr., I. I. Lemann, Louis J. Dubos, J. M. Batchelor, Arthur L. Whitmire, Isadore Cohn, J. A. Danna, A. S. Yenni, A. Granger, T. W. Kirn, C. L. Eshleman, P. L. Querens, H. W. Kostmayer, E. P. Lowe, P. C. DeVerges, T. J. Dimitry, D. F. Waide, E. Chas. Thornhill, R. B. Harrison, D. L. Watson, H. S. Cocram, F. M. Johns, C. Grenes Cole, H. N. Blum, W. Scheppegrell, P. Graffagnino, Allen Eustis, Chas. Chassignac.

Dr. G. A. Thomas, of New Orleans has returned from service in the U. S. Army.

Dr. Isadore Dyer is spending a few weeks vacation in French Lick Springs, Indiana.

Dr. Homer Dupuy, President of the Louisiana State Medical Society, who has been off on an extended vacation, has returned to the City and resumed his practice.

Dr. Alex. Craig, Secretary of the American Medical Association, is now recovering from a recent operation successfully per-

formed, and will very shortly return to his office in Chicago, Ill., to resume the arduous duties, pertaining thereto.

REMOVAL.—Dr. Felix A. Larue, from 1631 Constantinople St., to 922 Esplanade Avenue, New Orleans.

DIED.—On September 8, Dr. J. J. D'Aquin, of New Orleans, aged 48 years.

On September 10, Dr. Geo. Huhner, of New Orleans, aged 71 years.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

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**A Text-book of Physiology**, by Russell Burton-Opitz, S. M., M. D., Ph. D.  
**Practical Physiology**, by Russell Burton-Opitz, S. M., M. D., Ph. D.,  
 W. B. Saunders Company, Philadelphia and London.

The first is a text on physiology, largely illustrated, containing 1185 pages embodying in part the subject matter of a series of lectures delivered by the author to the students of the College of Physicians and Surgeons of Columbia University. Principles of Physics and Chemistry that are directly related to the subject matter of Physiology are briefly reviewed, and reference is made to comparative Physiology and Histology where necessary for elucidation of principles. The companion volume "Practical Physiology" by the same author is a laboratory guide consisting of fifty lessons, each lesson intended for one laboratory period of three hours. Beginning with simple experiments, the practical course is graded up to the more complicated procedures and a list of experiments to be demonstrated to students is furnished. Both the text-books and the laboratory guide will find a place in Physiological laboratories and serve both teachers and students of Physiology. The excellence of the text-book will recommend it also to the practicing physician who wishes to keep abreast of the advances made in physiology.

RALPH HOPKINS.

**A Text-book of Urology**, by Victor Cox Pedersen, A. M. D. Lea and Febiger, Philadelphia.

This is a complete work on urology in "men, women and children." It includes all urinary and sexual infections, with their sequels and result, but does not deal with syphilis or chaneroid; in other words it deals only with what the title of the book would lead us to expect.



Dr. Pedersen has had a vast experience and tells us, in addition, that the actual production of the volume has required four years of effort. Those two facts are sufficient to contribute large value to the book. It contains much of original matter and that which is compiled is well selected. An analogous comment would apply to the illustrations.

All told, we believe the author's desire to produce "a serviceable and accurate book" has been fulfilled. C. C.

**Principles of Human Physiology**, by Ernest H. Starling, C. M. G., F. R. S., M. D., Hon. Sc. D. (Cambridge and Dublin), F. R. C. P., Third Edition, Lea and Febiger, Philadelphia.

The third edition of "Principles of Human Physiology" by Ernest H. Starling is a comprehensive text-book on this subject. The text of 1315 pages is arranged in four books dealing with (1) general physiology, (2) mechanisms of movements and sensation, (3) mechanisms of nutrition, and (4) reproduction. The great part of the text is devoted to discussion and elucidation of principles. Descriptions of experimental procedures is mostly limited to accounts of one or two typical methods. The section on Sense Organs has been revised, and that on vision has been entirely rewritten. The volume contains 579 illustrations, 10 of which are in color. Features of the work are clearness of style and excellence of arrangement of material. Suited to the needs of advanced students of physiology and practitioners of medicine, the presentation of the subject is intended to emphasize the importance of thorough understanding of the workings of the healthy body. "Principles of Human Physiology" ranks easily among the best texts in this subject.

RALPH HOPKINS.

**Arteriosclerosis and Hypertension with Chapters on Blood Pressure**, by Louis M. Warfield, A. B., M. D., 3rd Edition. C. V. Mosby Company.

This book is a conservative and reliable guide to what is known about arteriosclerosis. As the author points out in the preface to this new edition, not a great deal has been added to our knowledge of arterial degeneration in spite of the considerable experimentation and writing on the subject. He has no new material to present nor new theory to defend. Very justly he insists that the proper treatment is that of the individual patient, not of the disease or of the stage of the disease. The practical suggestions are concrete, definite and helpful. Above all to be commended is the freedom from hobbies. I. I. LEMANN.

**The Medical Clinics of North America**. W. B. Saunders Company, Vol. 3, No. 5, Philadelphia Number, March, 1920. Number 6, Chicago Number, May, 1920.

These issues maintain the usual standard of excellence of this publication. It is striking how many papers are devoted to the discussion of diseases of the gall-bladder and the biliary passages and of other conditions simulating these diseases. Particularly interesting and timely are the lectures of Drs. Martin E. Rehfuss, B. B. Vincent Lyon and Arthur H. Hopkins on the newer methods of diagnosis and non-surgical treatment of gall-bladder disease.

I. I. LEMANN.

**Diseases of the Chest and the Principles of Physical Diagnosis**, by George William Norris, A. B., M. D., and Henry L. M. Landes, A. B., M. D., with a chapter on the Electrocardiograph in Heart Disease, by Edward B. Krumbhaar, Ph. D., M. D. W. B. Saunders, 1920.

The same cordial welcome awaits the second edition of this excellent text-book as was accorded the first edition. Nothing but what is commendatory can be said of it. The text is carefully done and the methods recommended sound. The illustrations and especially those of frozen sections, are illuminative and helpful. The new material added includes a comprehensive and instructive description of the recent influenza epidemic.

I. I. LEMANN.

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## PUBLICATIONS RECEIVED

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**C. V. MOSBY**, St. Louis, 1920.

**Exophthalmic Goiter and its Nonsurgical Treatment**, by Isreal Bram, M. D.

**The fundamentals of Human Anatomy**, by Marsh Pitzman, A. B., M. D.

**Hygiene, Dental and General**, by Clair Elsmore Turner.

**PAUL B. HOEBER**, New York City, 1919.

**The Theory and Practice of Massage**, by Beatrice M. Goodall-Copes-take.

**Autoerotic Phenomena in Adolescence**, by K. Menzies.

**The Diagnosis and Treatment of Heart Disease**, by E. M. Brockbank, M. D. (Vict.) F. R. C. P.

**W. B. SAUNDERS COMPANY**, Philadelphia and London, 1920.

**An Epitome of Hydrotherapy**, by Simon Baruch, M. D., LL.D.

**Medical Clinics of North America**, Vol. 4, No.1, July 1920.

**THE MACMILLAN COMPANY**, New York, 1920.

**The American Red Cross in the Great War**, by Henry P. Davison.

**WASHINGTON GOVERNMENT PRINTING OFFICE**, Washington, D. C., 1920.

**U. S. Department of Agriculture**, Service and regulatory Announcements. Supplement. Notices of Judgment Under the Food and Drugs Act. July 24 and 30.

**Public Health Reports**, Volume 35, Nos. 31, 32, 33, 34.

**Hygiene Laboratory**, Bulletin No. 120, February, 1920.

**The Case Against the Red Light.**

**PANAMA CANAL PRESS**, Mount Hope, Canal Zone, 1920.

**Proceedings of the Medical Association of the Isthmian Canal Zone**, July to December 1917.

### MISCELLANEOUS.

**Health Bulletin No. 21, Management of Communicable Diseases**, by Drs. Eugenio Hernando and Vincente de Jesus.

**Biennial Report of the Board of Administrators of the East Louisiana Hospital for the Insane. 1919-1920.**

**Principal Watering-Places and Climatic Resorts of the Czechoslovak Republic.**

**Occupational Diseases and their Compensation.** Address by Frederick L. Hoffman, LL. D., 3rd V. P., Prudential Insurance Co.

**A Review for 1919,** by George E. Vincent, President of the Rockefeller Foundation.

**The National Anesthesia Research Society, Bulletin No. 4, July, 1920.**

#### REPRINTS

**Concerning Rheumatic and Some Other Infections, with Illustrative Cases,** by S. E. Earp, M. S., M. D.

**Artificial Vagina,** by J. E. Engstad, M. D.

**Allergy, Anaphylaxis and Immunity in Hay Fever and Asthma,** by Wm. Scheppegrell, A. M., M. D.

**From the Public Health Reports:** No. 564, Industrial Morbidity Statistics; No. 567, Note on the Hygienic Laboratory Method of Standardizing Disinfectants; No. 568, The Weil-Felix Reaction as a Laboratory Test in the Diagnosis of Typhus Fever, by Ida A. Bengston; No. 569, Health Activities in Colleges and Universities, by John Sundwall, M. D., Ph. D.; No. 571, Malaria in England in 1917 and 1918, by H. R. Carter, M. D.; No. 572, Potency of Antimeningococcic and Antipneumococcic Serums; No. 575, Co-ordination and Expansion of Federal Health Activities, by B. S. Warren; No. 577, Botulism from Eating Canned Ripe Olives, by Chas. Armstrong, R. V. Story and Ernest Scott; No. 579, the Notifiable Diseases, Prevalence in Small Cities, 1918; No. 580, Treatment and Disposal of Sewage, by H. B. Hommon, J. K. Hoskins, R. W. Streeter, R. E. Tarbett and H. H. Wagenhals.

**MORTUARY REPORT OF NEW ORLEANS.**

Computed from the Monthly Report of the Board of Health of the  
City of New Orleans, for August, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	4		4
Intermittent Fever (Malarial Cachexia)			
Smallpox	1		1
Measles			
Scarlet Fever	2		2
Whooping Cough	4		4
Diphtheria and Croup			
Influenza			
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	37	28	65
Cancer	29	3	32
Rheumatism and Gout		1	1
Diabetes	3		3
Alcoholism			
Encephalitis and Meningitis	3	1	4
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	26	11	37
Paralysis	4	1	5
Convulsions of Infancy	1		1
Other Diseases of Infancy	16	6	22
Tetanus	1	1	2
Other Nervous Diseases	7		7
Heart Diseases	39	24	63
Bronchitis	1		1
Pneumonia and Broncho-Pneumonia	10	9	19
Other Respiratory Diseases	3	2	5
Ulcer of Stomach		1	1
Other Diseases of the Stomach	2	1	3
Diarrhea, Dysentery and Enteritis	19	12	31
Hernia, Intestinal Obstruction	7	2	9
Cirrhosis of Liver	9	1	10
Other Diseases of the Liver	3	2	5
Simple Peritonitis			
Appendicitis	2	2	4
Bright's Disease	10	4	14
Other Genito-Urinary Diseases	9	16	25
Puerperal Diseases	3	1	4
Senile Debility	1		1
Suicide	4		4
Injuries	23	13	36
All Other Causes	29	27	56
<b>TOTAL</b>	<b>312</b>	<b>169</b>	<b>481</b>

Still-born Children—White, 17; colored, 34; total, 51.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 12.91; colored, 18.44; total, 14.43. Non-residents excluded, 12.30.

**METEOROLOGIC SUMMARY (U. S. Weather Bureau).**

Mean atmospheric pressure . . . . . 30.01  
 Mean temperature . . . . . 81  
 Total precipitation . . . . . 4.18 inches  
 Prevailing direction of wind, southwest.



# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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ISADORE DYER, M. D.

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## EDITORIAL

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### DR. ISADORE DYER.

On October the twelfth, in the morning, a few hours before the time at which the writer expected to meet his co-editor in order to arrange the material for the present number of the JOURNAL, Isadore Dyer was called unexpectedly by a Higher Power. It seems unbelievable that one who was so active, who appeared so strong, who was so useful, nay, so much needed should thus suddenly be taken away from us!

Born in Galveston, Texas, not quite fifty-five years ago, he lived in New Orleans nearly thirty years, having first obtained his Ph. B. degree from Yale and the M. D. from Tulane. His attention was early directed to dermatology, and before settling in New Orleans, he had served as interne in the New York Skin and Cancer Hospital.

It is as a dermatologist that he was first known and it is as such and especially as an authority on leprosy that he became most generally and internationally known. His versatility is well established by the fact that he at various times acted in the capacity, always making good, of lecturer on skin diseases in Tulane, Secretary and Professor of skin diseases in the New Orleans Polyclinic, Secretary of the N. O. Sanitarium, Co-editor of this JOURNAL, president of the local and the state medical society, Associate dean and Professor of the Tulane School of Medicine, dean of the same school and of the School of Pharmacy, co-editor of the *American Journal of Tropical Diseases*, and an army medical officer, holding the rank of Colonel at the time of his death.

He was, of course, a member of all local, state and national medical societies of moment, often had served as an officer of such, and frequently represented various medical interests at national and international conventions.

His labors as dean of the School of Medicine deserve special mention and recognition. To them are due in great part the lofty standards of Tulane medically and the high standing of the College. For the last dozen years this has been probably the work nearest his heart. His place in the institution, no matter how worthy his successor, can scarcely ever be really filled. Respected and esteemed by his faculty, admired and confided in by the Board of Administrators, he was popular with and beloved of the students.

Dr. Dyer was a prolific writer for many years, not only in his specialty nor yet on medical subjects alone, editorially or otherwise, but in the broader fields of literature, not omitting poetry at which he was no mean adept. He had a facile pen, a rather ornate style, yet the happy faculty of driving home the particular truth he was trying to inculcate.

A man of tact and judgment, of courtly manners, firm though gentle, kind *par excellence*, he quickly gained influence and authority among the members of any body, large or small, of which he formed a part.

Having had the privilege of being a colleague and co-worker of his for about twenty-five years in the Polyclinic, the Sanitarium, on this JOURNAL, later in the University and on the *Tropical Journal*, we may be permitted to express our deep appreciation of

the many sterling qualities of our friend, our sincere grief at his loss, and our heartfelt sympathy for the loved ones he has left behind. *Requiescat in pace!*

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### FASTING.

The hunger strike now going on in Ireland has attracted general attention to the subject of fasting. As this is written the Mayor of Cork is said to have gone nearly seventy days without food. The long duration of the fast has led some to doubt whether it has been rigidly observed, especially as it has been estimated that the average individual can stand the total absence of food during about three weeks.

However, a study of the subject reveals the fact that a number of observations are on record as to cases of fasting for from 30 to 50 days. Many of our contemporaries will remember our own Tanner who fasted 40 days and came out none the worse for it as he died at past ninety years of age. Invalids and insane persons have done better, one of the latter according to Devillers, having gone 76 days without food.

It must be remembered that circumstances alter cases. The condition of the faster, both as to the soundness of organs and the mental state, has a good deal to do with the duration of his resistance. All else equal, the healthier and the better nourished he has been the longer he can last. The one whose fast is compulsory, the result of accident, such as shipwreck, does less well as his anxiety, exposure, effort of different kinds, use up his reserve more rapidly and often he succumbs in ten or twelve days. On the other hand, rest in the recumbent position, mental calmness and determination, the care and attention such as are lavished on the Irish mayor, all tend to increase the resistance and render possible the prolonged fast which he has endured.

Fortunately, when otherwise healthy, the voluntary fasters easily regain their strength and return to their normal state rapidly as soon as they resume their feeding.

**MEETING OF THE SOUTHERN MEDICAL ASSOCIATION.**

The fourteenth annual meeting of the Southern Medical Association will be held in Louisville, Kentucky, on November 15 to 18.

We are informed that the section programs promise a meeting of unusual scientific interest and that a very large number of reservations have been made in the hotels. The meeting places selected for the various sections are not far apart and that, we judge, is a detail of importance to the members in attendance.

It is the intention of the officers to make the scientific exhibit one of the outstanding features of this meeting. Space for it has been given in the Armory, where the registration office and the headquarters of the association will be located.

The social side of the meeting will be carefully looked after and the usual reunions and alumni dinners will add to the attractions of the meetings.

All are urged to arrive on the morning of the first day and stay to the end of the last day. We are sure that all will have such a delightful time that coaxing in this respect will be unnecessary and we hope that New Orleans and Louisiana will be largely represented.

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**THE EYE, EAR, NOSE AND THROAT HOSPITAL DRIVE.**

In a few days the Board of the Eye, Ear, Nose and Throat Hospital expects to launch a so-called drive in order to secure funds sufficient to build a new hospital building, modern in every respect, and equipped so as to enable the staff to furnish in the most acceptable and efficient manner the special services needed by those who apply for treatment at the institution.

The good work done up to date by the hospital is too well known by the members of the profession for it to be necessary for us to do more than remind them of it. To those who have visited the present building during the past year or two it is unnecessary to describe the need of a new building, it is self-evident. To any others we can state that the need is imperative; the old buildings improvised into a hospital many years ago, are past repair and it is impossible to continue working therein. The only solution is to



build and to build larger and better in order to provide for the progressively increasing clientele during many years to come.

The hospital owns enough ground and the location is as central and convenient as possible, hence we hope the amount needed will be secured in order to put up a hospital which will be creditable to the city and to the cause to which it is dedicated.

The members of the profession, apart from contributing of their own means as they can afford, are urged especially to encourage and stimulate their friends and acquaintances to give and to give liberally. The sum needed is large, yet as the hospital's field is not limited to the city but includes the entire state, it should not be difficult to obtain it.

Let us boost the efforts of the Board and its Committees as none like the doctors can make the public understand the worthiness of the cause and the necessity for adequate funds.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### IMPORTANCE OF EARLY DIAGNOSIS OF RECTAL DISEASES.

By A. G. HEATH, M. D., Shreveport, La.

The wreck of homes and happiness; the loss of opportunity, both to the patient and the physician; the hopeless invalidism; the prolonged discomforts; the numerous deaths and many jeopardies in life, not to say the lost reputations of doctors, through failure or delay in the diagnosis of rectal disease, are scarcely dreamed of by the general practitioner or surgeon. But to the specialist, who is daily in contact with these conditions, they are an old story more frequent in rectal diseases than in any others, for the simple reason, that those maladies, though most amenable to treatment in their early stages, proceed more rapidly than diseases elsewhere and more frequently become inoperable. Or, if operable, they have proceeded to such destruction of tissue that it is impossible to restore the parts to a normal condition. Such a condition renders prompt and accurate diagnosis more important in these diseases than in any others.

Why this state of affairs has so long been unobserved, or neglected, by our schools and colleges it is hard to tell; but I venture to say that there are a very small number of physicians that ever received a single course of lectures on rectal diseases in his entire undergraduate career by a recognized proctologist but received his training from the men on general surgery. If such a low estimate is placed on this branch of medicine, as a specialty by the teachers of medicine, why should we expect any more of the students when they become practitioners? why should we expect men to examine the rectum when they never have been taught the importance of doing so? why should we expect men to use a proctoscope when their professors have never thought it necessary?

We see more quack advertisement about, more nostrum remedies

presented for, more irregular practitioners holding themselves out to cure hemorrhoids than any other disease (with the possible exception of venereal disease). In many quarters intelligent people, who would not think of consulting an unethical practitioner for any other condition, will consult the so-called pile specialist, who holds himself forth in the daily press, because they believe that members of the regular profession do not treat rectal disease. It is perfectly astonishing to what extent this belief is held.

There must be reasons for this, and the reasons are: the lack of instruction to the medical student on the subject of rectal disease, in the first place; the paucity of such instruction when given as an incident in the teaching of general surgery; the repugnance with which the average practitioner approaches a case requiring rectal examination; the cursory character of such examination; the distaste of the average practitioner for local treatment of the ano-rectal region; the inability to make a correct diagnosis; and the superficial treatment given and the early discharge of the patient by the practitioner, who is anxious to get rid of a case that is unpleasant for him to treat—all are responsible for the position which the average general practitioner occupies today in the diagnosis and treatment of rectal diseases.

It is the action of the profession itself which has created the special field of proctology, the anus and rectum being organs peculiar to themselves and being subject to many medical and surgical diseases in the same way as the eye, the ear, the nose, the genital and urinary organs; and call for just as much special medical as surgical care. The general surgeon knows nothing about, and cares less for, the medical treatment of these organs; and the general practitioner who is able to treat the medical condition is not as a rule, properly equipped to do so. Thus the proctologist came into existence, a man who, by special study of this particular region of the body is able to give special care of either a surgical or medical nature, and often both in the same case, as may be required. With his attention directed particularly to this line of work, his operative measures are directed largely along the lines of conservatism. He endeavors to save as much tissue as he can and cuts as little as possible, and by intelligent after care to promote healing much nearer to the normal,

as a rule, than does the man who "cuts a fistula and ties a pile," and allows it to go at that.

The rapid progress which has been made in the study of toxemias and autotoxemias, however, has drawn attention to the importance of the large intestine, and especially its lower end, from which so much absorption takes place; and the time has now come when stool examination and proctoscopy will be known to be as important as blood examination and urinalysis.

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### RETURN OF CHRONIC URETHRITIS.\*

By Dr. ALEX. RENAULT, Cochin-Ricord Hospital, Paris.

Translated for the JOURNAL by DR. CHAS. CHASSAIGNAC.

It may be stated at the outset that it is less difficult to obtain the disappearance of the "morning drop" than maintain its final suppression.

What happens in practice? With hard work, by means of antiseptic or alterative irrigations, say with permanganate of potassium, nitrate of silver, corrosive sublimate the physician has succeeded in drying up the canal. Several examinations upon arising in the morning confirm this fact. Upon pressing the canal, from the perineum to the meatus, no leakage is discovered and the patient, rid of his nightmare, is delighted. Nevertheless a few filaments persist in the urine and fall slowly to the bottom of the glass at the first voiding. It may be added that in a patient who has dragged a long time with a blenorragia it is scarcely possible to cause these filaments to disappear completely. They indicate that the sensitiveness of the urethral mucous membrane continues and that the slightest excess would cause an exacerbation.

Outside of the prolonged observation of a strict diet and careful habits, do we possess means to strengthen the canal, in other words to inure it against the repeated irritations to which it is exposed daily? we can answer, categorically, no. A more or less persistent continuation of the remedy which seems to have brought about the cure would avail nothing. On the contrary it would irritate the canal and would increase the likelihood of the return of the "drop." which often had for weeks already resisted the

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\* From the *Monde Medical*, Sept. 15, 1920.



efforts of the specialist. There is nothing to be expected from the so-called anti-catarthal medication which might be exhibited internally.

It is to diet and hygiene that we must resort. Let us see what positive recommendations must be made to the patient. As far as drink is concerned, they are the same as if we were dealing with an acute urethritis, that is that the patient must be satisfied with plain water and milk. Mineral waters as they possess more or less diuretic qualities, must be put aside. It is unnecessary to add that wine, tea, coffee, and especially liquors must be strictly interdicted.

Concerning solid food the rule need not be so severe, yet dishes with vinegar and acids should be omitted and especially asparagus which congests the urinary organs and tend to cause a recurrence of the leakage.

It should be added that the patient must abstain from walking, pushed to fatigue, from dancing, from sea or river baths, from horseback riding and especially from the bicycle which tends to congest the pelvic organs.

Now, what is very important to know is the time during which this draconian existence must be maintained. Yet nothing is more difficult than to set an exact limit. It is not sufficient to establish that the morning drop has disappeared thus taking away the chance of discovering any gonococci. This apparent cure does not permit in any way to weigh the resistance of the canal against the assaults of a normal life.

In my opinion, three months at least are needed before touching slightly alcoholic drinks, such as diluted wine, those whose action is mostly diuretic, such as coffee and tea, or the sweet cordials. For beer, champagne, and spirituous liquors six months are necessary. Even then they must be used with great moderation, for a chronic urethritis even when well cured leaves the mucous membrane in a state which must always be prudently considered as sensitive. It goes without saying that the longer the disease has lasted the more marked will be the lack of resistance.

Precautions should be multiplied especially at the time of sexual intercourse. It is important that contact should be neither too frequent or too prolonged. I may be permitted on this point to go into some details.

First, is it indispensable to delay for the three months already spoken of the resumption of sexual life? No doubt this long continence would be preferable, but we must take into account the imperious sexual needs of some individuals and consequently of the constant erethism resulting therefrom. This erethism keeps up an irritability of the canal which predisposes to a return of the the drop. Hence, after having advised the patient to wait as long as possible, it is preferable to authorize a brief indulgence, together with the use of a preventive. It must be well understood that during that interval of three months, which I consider necessary at the least, this authorization is to be granted only in case of urgent need.

Besides when sexual indulgence can be permitted there are still some precautions to be taken in order to guard against any relapse.

First of all, it is important to beware of the monthly period. The menstrual flow being very irritating, would scarcely fail to provoke a return of the discharge. Prudence, then, directs to abstain for one or two days before the expected period and to resume relations only after its complete termination. Coitus is not to be repeated in the course of a night and it is at night it should take place. The patient should take the precaution of urinating previously. I attach a good deal of importance to this recommendation for two reasons: if unfortunately the few filaments, which nearly always persist in the canal and are expelled at the first micturition, still contained gonococci there would be a risk of the woman being infected; on the other hand, it must be remembered that leucorrhœa, which is so frequent especially in the women living in large cities, accumulates during the night in the vagina and may irritate the urethra coming in contact therewith. Finally, coitus must not be repeated oftener than two or three times a week and the patient must avoid all sexual excitement at other times.

Conditionally upon the observation of the above rules, the patient will be free from relapses. But, again, he must not forget that his urethral mucous membrane requires careful handling for a period of time the length of which it is difficult to define, considering individual tendencies, if the return of noxious germs is to be avoided. In conclusion, I consider that henceforth all sexual stunts are to be eliminated.

As a proof of the ease with which gonococci reappear when the canal is irritated, I shall quote a typical observation reported at the International Congress of Dermatology and Syphilography of 1900.

A patient on the eve of his marriage and dreading on account of a gonococcal phobia, that he is not cured, consulted a specialist. Examination of the urethra failed to show any leakage and shreds had disappeared from the urine. The right lobe of the prostate barely revealed a slight thickening. In order to clear this up, the specialist resorted to a massage and only filaments and leucocytes were discovered in the urine but no gonococci. Successive massages were followed by the same negative results. However, in order to be done with this minute infiltration, the specialist resorted to dilatation with the Oberlander instrument. Four days after the second seance the canal was running and the secretion swarmed with gonococci. To resume, in this case there dwelt in the midst of the prostatic infiltration contagious germs which had been revealed neither by massages, by the ingestion of strong drinks, nor coitus followed by the use of preventives. In no case is it possible to affirm that there no longer exists any gonococcic nidus in the canal.

Nevertheless, from a practical standpoint, when examination of the canal in the morning reveals only a slight moisture of watery appearance, accompanied by the settling at the bottom of the first glass of urine of one or two heavy filaments and especially when the previously indicated precautions are observed, contagion does not follow. There would be a risk of its occurrence only if the canal suffered from a repeated or strenuous irritation.

However it may be, a patient suffering from his first gonorrhoea cannot be urged too strongly to be very thoroughly treated and to avoid confusing an apparent with a real cure. It is incumbent upon the physician to post him as to the disastrous consequences that an inflammatory residuum might entail. Also he should not depend upon his client even when the latter affirms that the canal is completely dry. He is under obligation to check it up himself on at least two mornings, with an interval of a few days between, as the last traces of infection accumulate as a rule during the night.

The first gonorrhoea, lasting only six weeks or a maximum of two months, allows the mucous membrane to return to a normal state and even to regain its former resistance, while the persistence

of a morning drop, besides the difficulty of its subsidence and the fear of stricture in the future, leaves the urethra in a state which it is prudent to consider as one of indefinite sensitiveness.

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## SCIENCE AND PRACTICE IN THE FIGHT AGAINST MALARIA.\*

By PROFESSOR B. GOSIO, Director of the Laboratory of Micrography and Bacteriology of the Department of Public Health, Rome.

As a corollary to a long period of convergent studies, science was at last enabled to make a definite pronouncement as to the mode in which malaria is spread from the sick to the well; whereupon there arose a blind faith in our ability to obtain a quick and complete victory over this world-wide pest. And this faith was based, not only on the encouragement which, in fighting a disease, comes from knowledge of its cause, but above all on a clear conception of the very simple means of breaking, at one point or another, what was then called the epidemiological chain expressed in the formula, mosquito + malarial patient = malaria.

Many were the infallible measures for destroying the mosquito or avoiding its bite, and safe methods were proclaimed, either of treatment or of prophylaxis, for removing the sources of infection, the human malarial foci. New Archimedean principles were applied to medicine: some said, "Give me a net, and I will defend mankind from malaria;" another demanded quinine, and another petroleum. The excitement caused by the scientific discovery of our mysterious enemy made us see in a flash the trusty and irresistible weapons which would shorten the road to victory; just as the sight of harbour abates the storm, shortens the voyage, and frees the sailor from all his hardships.

But hopes nourished on an excessive idealism must inevitably wither at the touch of reality. More than two decades have passed since the memorable discovery, and yet it cannot be said with assurance that much progress has been made in delivering the nations from this dire scourge. And if those who cry failure are unwarrantably pessimistic, it is none the less true that we are still far from our goal. The fall in the death-rate is, however, an im-

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\* Reproduced from the *International Journal of Public Health*, September, 1920, Geneva, Switzerland.



mense and indisputable benefit. In Italy during the period from 1887 to 1902, immediately preceding the enforcement of the anti-malarial laws, the records show an annual average of 15,000 deaths, while during the three years 1903 to 1905, which saw the beginning of this enforcement, the average fell to 8,000, and then to 3,700 from 1906 to 1912, to 2,664 in 1913, and again to 2,045 in 1914.

Yes, many lives have been spared, and that is a long step forward. But the object of preventive medicine is to extirpate the noxious seed of the fevers, and any success in reducing the deaths counts for little if the survivors are not healed. Reasoning crudely—not to push the argument too far—it can be stated that to delay the death of a malarial patient, without curing him, is to add to the number of carriers and to enlarge, for the healthy, the dangerous area. But all paradox aside, it is certain that from the point of view of the public weal no victory is real that does not overcome the incidence of the disease and suppress its sources. Failing this, we can only claim to have more or less scotched an ever threatening enemy; his re-awakening is in fact an ever present possibility, as happened, for example, in many places and to a really formidable extent during the war.

From the point of view of social hygiene, properly so called, the malaria problem is still almost unsolved. What has been done suffices only to show that if we continued in the right way, we would conquer; but in reality all is still factitious and in the palliative stage. Governments have shown their interest by means of laws and the encouraging example of model demonstrations, but their efforts have rarely met with responsive good will on the part of those whom they have attempted to aid. War, with its moral and material disturbing influences, was sufficient to undo every gain and to dash the hopes of a new dawn in the countries smitten with the malarial scourge. The disease has reappeared in localities which were thought to have been definitely freed from it. And since this deliverance dates back to some time previous to the discovery of the life cycle of the malarial parasite, certain cynics have not refrained from making the sarcastic observation that the advantages which ignorance had gained, knowledge was not able to maintain. No wonder, therefore, that the onlookers and the ill-informed should disparage our modern theories of etiology as being inexact or at least incomplete, if malaria can origin-

ate in any other way than through the bite of infected mosquitoes.

To find a suitable remedy for this state of affairs one must first go deeply into the genesis of this supposed failure and, with a criticism free from prejudice, define the nature of its causation.

Its causes are of a twofold nature, moral and material. Predominant amongst the moral factors is undoubtedly a certain dangerous sense of satiety, which these very discoveries in the field of etiology bring with them. After so many years of groping in the dark with such diverse opinions on the mechanism of the infective process, and after so many fruitless researches in opposite directions and with incongruous results, with warring schools advocating half-baked measures, the profession unexpectedly found itself confronted with the scientific solution of the problem. This gave rise to a sort of exaltation almost sufficient in itself to make us forget that there was still a long and rough road to travel before we could raise our practice to the illuminating level of our science.

To dream, when one ought to act, is a common and very human failing. Scientists who contributed to the discovery, transmitters who spread the message abroad, and those who embroidered its minutest details, have all seen much, perhaps too much, in their dreams. Misjudging the path they had to follow, a path bristling with thorns at every step, they declared that, with the enemy known and his methods known, victory was easy. They should rather have told the disconcerting truth about the immense labour involved in a rational organization of the fight against this noxious weed, deeply rooted for ages in the human race. They should have given us timely warning that even if the scientific discovery is everything in pointing the way for practical measures, it counts as nothing as far as action is concerned. The discovery, in our case, is tantamount to a good programme. It must be well followed up to bring success; just as when we wish to climb a mountain, it is not enough to get a clear view of its peak, we must trudge the intervening ground patiently, step by step.

Also in the moral sphere, a little less deceptive, but still deceptive, comes the scheme of the so-called "model demonstrations." They did, indeed, put into practice the dictates of science; but limited, as they were, to narrow fields for brief periods, they could do little more than demonstrate the correctness of our theories. With rare and favoured exceptions, few of them have done much

practical good. It is like trying to solve the problem of general undernourishment by providing small groups of people with good food. The model demonstrations, especially those carried out on a fairly large scale, are valuable as training centres and as a stimulus to a wide-spread campaign. They are a stage which must be passed through before prophylactic measures can be universally applied. But if our efforts are limited to these demonstrations, they partake more or less of the nature of artistic performances; in appearance they may carry conviction, in reality they accomplish little.

Among the material causes of diminishing returns in the campaign against malaria is the tendency to over-standardize it. Rules to be applied to large communities must not be too simple or rigid. This is always a danger, and especially in matters of health; for here the necessity of treating individuals and not diseases is never properly understood, and considerations of time and place and various modifying circumstances are so important. The tendency, however, in academic circles, and amongst individuals propagandists, has been to foster the system of easily applied ideas, perhaps to give the public more encouragement or less inconvenience, or perhaps out of a mania for acting quickly. One announced that all that is necessary is to treat the malarial patients during the winter, another held the fort with a small daily dose of quinine in times of peril, a third wanted to petrolize every puddle, and others still were content to isolate man from the mosquito.

All the methods are based on sound principles; but put indiscriminately into practice, struggling with unforeseen difficulties, and made responsible for exaggerated claims, they were doomed, if not to failure, at least to the accomplishment of ridiculously limited results.

Owing to an imperfect study of the actual conditions under which they were to be put into practice, the schemes proposed were not without defects, which entailed disappointing returns. Robert Koch, with the authority of his name and his wide technical training, advised that the human foci of malaria be cleansed up by means of intensive treatment in the pre-epidemic season. The "bridge," as he described it, joining one year to the next, would thus be broken, and the mosquitoes would be deprived of their sources of infection.

Theoretically, this was a very important proposal, appealing to the reason with a seductive clearness. For in the epidemiological chain the human link seemed to the observer to be the one most readily controlled, involving the fewest unknown factors. But in passing from theory to practice it was soon evident that the delayed treatment of malarial patients was an obstacle of unforeseen magnitude. To wait for the winter—no one doubts it nowadays—meant losing the best opportunity of cure. On the other hand confining the treatment of the patient to the season in which he contracts the disease, does not suffice, as a rule, to protect him from relapses. Having thus to conform to the demands of practice, the scientific principle becomes complicated and difficult of application. The malarial patient must be followed for months and months, sometimes for years; care must be taken to see that even if he changes his place of residence, he does not lose contact with his physician; and we must be very sceptical and not regard him as cured until after long and very thorough testing. To extend such vigilance as this to large groups of suspects is one of the most arduous tasks; and it is here that the grave defects appear in the belauded plan of protecting the healthy by treating the sufferers from malaria.

Not less imperfect was the success of the quinine prophylaxis. Here, too, the weapon was an excellent one in theory, and logically the deduction was clear: if quinine cuts short the malaria fever, it must also prevent it; the thing to do, therefore, was always to maintain this specific, in small amounts, in the circulation of a healthy man, thereby keeping his blood refractory to the growth of the malarial germ. This was all very fine, and, thanks to favorable circumstances, encouraging instances of success were not lacking. But in the wide field of reality it soon became apparent that the dosage was an important factor in the achievement of the results desired. From 20 centigrammes of quinine the dose had to be raised to 40 and then to 60, and even that did not seem a sure defense. Going beyond these limits, one could not always count on the individual's tolerance. Not that any real harm would be done, but at any time slight disturbances might occur, which, though transient, would be sufficient to render the practice disagreeable. Moreover, the quinine must evidently be given not only while the risk of infection lasts, but for long after. In the opinion



of some the greater part of the year must, in districts where malaria is rampant, become a period of daily cinchonization. Is this practical or advisable? Can one be sure that it is always harmless, particularly to young children?

Nor is this all. The standardization of the drug prophylaxis leads inevitably to the giving of the same doses to the well as to the sick, to those who are face to face with serious peril as to those who enjoy a certain immunity; for some too much is done, for others too little. The method requires enormous quantities of the drug, at what expense it is easy to imagine; and perhaps it is not always those who need it most who reap the benefit. Then there is the problem, a most difficult one, of putting this scheme into practice. Proof is not lacking that, without coercion, with measures of this kind, it is difficult to ensure compliance. But this coercion implies a law, and the law invites you to seek out the sheep and the goats and to discriminate between them with suitable rewards and punishments. How are you going to tell them apart? Do you propose systematically to look for the Tanret reaction in everybody's urine?

Much the same is to be said of the mechanical defenses. For it was precisely here that in theory the ideal protection was dreamed of, and that in practice the widest loopholes were revealed. So, too, with all the plans for killing larvæ and mosquitoes: thinking it out, it is the easiest thing to destroy the insects that infect a locality, but in carrying it out we run up against a thousand unforeseen obstacles and unknown factors, which, if they do not render useless any serious attempts of this kind, at least minimize the practical results under ordinary conditions. Thus, even when everything that is possible has been done, judgment must be reserved as to whether the object has been permanently achieved.

While analysing the causes of the failure of so many bright hopes in the war against malaria—hopes conceived before our scientific knowledge was tested in practice—we must not ignore the lack of perseverance in applying the prophylactic measures and the scanty and unsuitable nature of the organizations which were entrusted with the task.

Lack of perseverance is an outcome of the mad desire to accomplish results quickly. Disappointment dampens the ardour, but is

a great stimulus to our hypercritical friends whom we have already mentioned; it gives them a new pretext for raising doubts as to the truth of the modern teaching which has inspired the campaign against malaria. If your doctrine, they say, were true, surely when the fight has been carried on all these years, under its guidance, malaria would have disappeared instead of being today just as rampant as before, or in some places even more so.

The truth is that the army has marched badly and has given way to weariness too soon; the routes mapped out by science were prematurely abandoned because they did not lead to the expected *veni, vidi, vici*. No measure was carried out as extensively and thoroughly as the success of the cause required. And so the longed-for deliverance from the malarial scourge resembles one of those mathematical calculations which are clear and convincing because they work out perfectly on paper, but which in their practical application do not command sufficient persevering labour.

But of all the causes hindering the practical advance of malarial prophylaxis the most sinister is the scanty and unsuitable sanitary organization of our communities, an organization which, though perhaps well enough adapted to dealing with other diseases and with emergencies, is quite unequal to the task, and sometimes does harm, with respect to malaria. I call it the most sinister factor, because it entails the repetition and exaggeration of all the other faults, whereas if the profession had everywhere been properly organized, and if the organization had been maintained at the level of modern requirements, it would have found in itself the forces and the courage necessary to overcome the defects I have described.

To understand the disastrous effects of this cause one need only consider the nature of the disease and its very peculiar requirements in the matter of therapy, for after all, the treatment of malaria still remains the fundamental means of bettering conditions.

The feature of practical utility in the modern doctrine of the pathogenesis of malaria is that which brings into relief the fact that the infection is indirect. With this conception malaria fell into the category of diseases in which the efforts of the sanitarians must be chiefly directed towards extinguishing the infective foci. Every patient who is cured means another focus extinct. The meaning, however, of the word "cured" must be clearly defined. It means

here the absolute disappearance of the parasites from the blood, without the possibility of an endogenous relapse; it means the return to such a state of health that a new attack of fever can be brought about only by the man being bitten again by infected anopheles. In short, from the point of view of hygiene, what is wanted is a cure in the strictly scientific sense of the term; and before we can say that such a cure is attainable, we must examine the conditions which it implies.

There is much discussion as to the possibility of curing malaria. Some deny it, stating that treatment, at the best, can only render the disease latent. A clinical cure is the only one they acknowledge. No doubt they exaggerate. They are right only as regards one type of cases, the chronic forms in which the parasite acquires a permanent home. It is precisely the prevention of such cases which calls for diligence and intelligence in the physician. If, therefore, we can rest assured that the question of the underlying principles is settled—and endless statistics prove that it is—the conditions under which those principles can be put into practice are certainly not so simple as would at first appear. The physician must be called in at the onset of the disease, follow the patient for months, and individualize the treatment. The specific remedy and its adjuvants must be continued through a long period. And, finally, the patient must be convinced—no easy task—that feeling well and being able to attend to his business are no justification for considering himself to be free of infective organisms, which may remain in his blood for years in a latent condition. Is our public health organization equal to the task? Is it to be expected that our state-subsidized physicians (*nostre condotte*) can carry out such a serious and difficult duty? Certainly not. Deficient in number, with inadequate means at their disposal and insufficient material and moral support, and working over a vast field with a constantly shifting population, these physicians of the *condotta* cannot nowadays keep in close enough touch with the sufferers from malaria to eradicate the disease. As a body they lack training and they need assistance, nor are there facilities for assuring their presence in sufficient numbers in any locality where their services may be needed. Their work is in keeping with the old clinical idea of prompt help in cases of serious illness and certainly not with modern hygiene which demands the “improvement of the human

environment." There are today very few sanitarians who can assume a task of such magnitude as this and at the same time feel assured of their ability to carry it on.

Moreover, the sanitary personnel at the disposal of the physicians is even today very scanty, ill-chosen, and poorly trained, and receives little material or moral encouragement. They do their best, considering that they have many other duties to attend to, but their best amounts to little and is altogether inadequate to raise practice to the level of science.

Up to now I have spoken only of the medical aspect. A well organized antimalarial service cannot do without competent management and adequate labour for the complex physical task of modifying the environment of the malarial mosquitoes. This task is a long, slow, most laborious one, if the results are to be appreciable and lasting. Any one taking all this into consideration is easily convinced that, except in some very circumscribed areas, it is ridiculous to count upon our present executive and technical equipment as a defense against the scourge of malaria.

After going broadly into the causes of this lamentable lull in the fight against malaria, it is easy to suggest the remedies; so easy that no writer on the subject can, without some twinges of conscience, continue to theorize when so much practical work is needed, or go on outlining programmes and tracing plans of attack when time and experience have made it clear that neither can be carried out with the forces and the means at our disposal; when there is no great influence directing all our energies into the one channel, inspiring us to avoid all side issues and make for the final goal; when, in short, we are not yet doing earnestly and on a grand scale a job which so far has only been tinkered with in a patchy and temporary fashion.

There are countries with excellent laws and excellent instructions for carrying them out. Those of Italy, for example, dealing with the antimalaria campaign, are a model of wisdom and of the practical application of academic ideas. But in Italy, as elsewhere, very little progress has been made owing to lack of teamwork and to differences of opinion, and above all because the available means and equipment are insufficient. Throughout the world this deficiency is more or less noticeable, a want of men devoted to the



cause, a want of materials upon which to lay a solid practical foundation for the desired deliverance from a disease which lords it over every race of mankind.

We still soothe ourselves with the mirage of science triumphant over the malarial mystery and with the clarity of our logical deductions. We ought rather to be up and doing, travelling the slow, laborious road with plenty of faith, certainly, but without any illusions as to brilliant victories which are not often the reward of such battles as these. For the simplified schemes must be substituted a discerning appreciation of the real technical possibilities. The directing body must be expert in all the means and all the systems, medical and zoological, of fighting malaria. The executive programme will be drawn up after a detailed study of each field of action, for the characteristics and peculiarities of any proposed sphere of action carry great weight in deciding what lines are to be followed.

The crux of the problem is this: to attack the enemy after mature investigation, without preconceived notions and with overwhelming forces. This simple formula illustrates the necessity of having better and greater armaments than heretofore, as regards both personnel and technical equipment.

As for propaganda, it has already been sufficiently provided for. No one can deny its great usefulness, especially in the school. But there is the risk of its being merely a flower without fruit, unless care and diligence are used in following its maxims so that they gradually become incorporated into our habits of life.

At this point reappears the urgency of providing labourers, the necessity for a new militia, well trained and organized, aware of the various phases and aspects of the complex problem, armed with every useful weapon, and working with the physicians, sanitarians and directors. Such an organization might indeed carry out what has so far been largely a dream. Here we have the rank and file with which to wage a war conducted hitherto without any real army. This is the hand that will grasp what has so far been grasped only in imagination.

To conclude: the mania for short cuts in antimalaria work has led us into doubts even of its scientific principles. Let us return to the main roads, with more constancy, more means, and more willingness to face the vicissitudes and sacrifices incident to all long and difficult labours.

## NOTES ON TROPICAL DISEASES.

(From Bulletin de l'Académie de Médecine, Paris.)

By LODILLA AMBROSE, Ph. M., New Orleans.

## PLAGUE.

Kermorgant<sup>1</sup> communicated data furnished by physicians (Colomb, Huot, Lafont) of the colonial forces on the epidemic of plague in Dakar and Senegal from April, 1914, to February, 1915.

It started among natives of the port of Dakar, and was evidently brought from Casablanca, Morocco, by a vessel carrying 8 Europeans and 850 natives, *tirailleurs*, although extreme precautions were taken when the vessel arrived. Plague patients were taken to the hospital, corpses were buried at one and a half metres after immersion in quick lime or cresyl. Natives inhabiting contaminated houses and those near by were taken to the lazaret. Cabins which could not be disinfected were burned. Dissemination by rail was prevented by refusing passage to natives from Dakar. The natives whose houses had been burned were detained in a segregation camp, and then removed to a newly constructed village a certain distance from the city. Most of the native quarter of Dakar was evacuated and destroyed. Measures based on the same principles were used in the contaminated centres of the interior. In Dakar after the isolation of suspected cases and the burning of contaminated cabins hardly any case of plague was reported. The Haffkine vaccination was made obligatory for natives in Dakar.

The epidemic started in April, but it was not until July that plague rats were found among those examined, and these came from vessels of the marine and from low quarters of the city. Deratization was done by periodic sulphuration of sewers, and by traps, poisons, bounties, virus. There was during the epidemic period a very high mortality among rats, and an abnormal mortality of other animals. Kermorgant emphasized the danger of the propagation of plague by *cats*.

The plague developed in three forms, pulmonary, septicemic and bubonic. The pulmonary was the first form manifested, and then contagion was direct from man to man by sputa, nasal secretions, and the excreta. The pulmonary cases were all fatal. Later on in

1. Kermorgant. *Épidémie de peste qui a sévi à Dakar et au Sénégal d'avril 1914 à février 1915*. 3. s., lxxvi, 126-133.

July with the bubonic forms of less rapid evolution, serotherapy and adjuvant medication (especially camphorated oil in large doses) gave good results in patients treated in time, or in those who had the benefit of one or several antiplague vaccinations. There were only two cases of plague charbon, but various vesicular eruptions were seen which swarmed with plague bacilli. There was an ambulatory form with buboes and hydroadenitis which recovered without treatment.

In this epidemic it seemed evident that man contaminated the rat, this conclusion being based on the complete absence of plague findings in rats taken alive and examined in the laboratory for certain definite periods.

Vaccinations with the Haffkine lymph (three vaccinations to a person, the dose varying) were done to the number of 130,000 for the entire colony. Infants of 18 months and over bore the successive vaccinations well. In Dakar 1,600 habitations were destroyed. In the interior whole villages were burned, and then rebuilt in new locations. Deaths were estimated at nearly 9,000. In infants the disease ran a relatively benign course. Among Europeans there were only 7 cases with 3 deaths.

“The conclusion from the facts observed is, that, during an epidemic of plague one must not be contented with making vaccinations; if all the plague foci ferreted out are not destroyed, if the inevitable disinfections and segregations are abandoned or are too late, if, in a word, the measures of preservation are not employed simultaneously, the favorable issue of a sanitary campaign may be endangered, and the plague can then install itself definitely in the country.

“What has taken place in Dakar in the course of this epidemic proves once more the advantage that there would be in having the native city completely separated from the European city. In fact, a city like Dakar, already visited by various endemics and epidemics, will not find definitive security until the day when this separation shall have been effected. In this way, the sanitary surveillance of the native foci will be easier and much more efficacious.”

**BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.**

By P. T. TALBOT, M. D., Secy-Treas.

The Executive Committee of the Louisiana State Medical Society held one of its regular meetings in New Orleans, October 6th, 1920. This was one of the most enthusiastic sessions held by this body, only one of the members being absent.

One of the important subjects taken up at this time was the arranging for Post-Graduate course to be extended to the members of the Louisiana State Medical Society. This was reported upon, at length, by the Secretary-Treasurer and the Executive Committee has approved of the plan, making provisions for the appointment of a Committee, by the President, to take up this work at once. The President will appoint this Committee very shortly, at which time they will begin at once arranging for the curriculum, etc., so that same may be available to our members at the next annual meeting.

We are thus endeavoring to add an additional attraction to active membership in our State organization. We do hope that our membership at large will recognize the advantages of such opportunity and as many of our members as possible will be registered at our annual meeting next year. Also, we feel assured this will give added stimulus to other physicians in the State who are not members of our organization, to become one of us at once.

If this new advantage of the State Medical Society proves a success, which I am sure it will, we will have added, in my opinion, one of the most important assets for the members of our organization.

Each and every one of us enjoys unusual benefits by being a member of our State organization,—for example the protection afforded by our Medical Defense Fund, in mal-practice suits; the eligibility for membership in the American Medical Association, the greatest of our representatives in Organized Medicine, and in the Southern Medical Association which has become the most important organized factor in Scientific Medicine in the South; the advantages of a Medical Journal, besides the social and scientific opportunities incurred as a member of our State organization. We



have thus tried to make the Louisiana State Medical Society as attractive as possible to its members and will not halt in our endeavors until everything possible has been accomplished and every opportunity for Medical advancement and protection is afforded our members.

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Very shortly the Secretary-Treasurer will announce the Chairmen of the various sections of the Scientific Program for our annual meeting in New Orleans, April 19th, 20th and 21st, 1921. At our last annual meeting the Executive Committee dispensed with the Scientific Program owing to the proximity of the American Medical Association convention. In view of this fact we anticipate, with a great deal of pleasure, that our next Annual Meeting will be rich with valuable contributions from our membership. The year's rest from scientific contributions, we hope, will give added zeal to our members at the approaching meeting of the Louisiana State Medical Society.

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In connection with our State Medical Society and especially in referrence to our Medical Educational work we should not let the opportunity pass to deplore and lament the loss of one of our esteemed members, Dr. Isadore Dyer, Dean of the Tulane Medical School, New Orleans, La. While Tulane Medical School has lost its Dean, The Louisiana State Medical Society has lost one of its former Presidents, and a man who has always stood for the highest in Medical Education. Throughout his Scientific Career he has added much to Medical Work and through his assistance and activity in our State Medical Society has reflected, in many ways, on the up-building of our State organization.

In our opinion his departure came at a time inopportune. His work in Medical Education, while always of the highest character, had not yet reached the ideals for which he no doubt was planning. His contributions to Medical Science and his activities in both State and National Medical Education will remain a monumental attestation of his value to the Medical Profession.

## NEWS AND COMMENT

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**PUBLIC HEALTH HOSPITAL OPENED.**—The U. S. Public Health Service on September 30, opened its Marine Hospital in Chicago as a general clearing house for soldiers and sailors residing in the States of Illinois, Wisconsin, and Michigan, who are suffering from nervous and mental diseases. Dr. L. M. Wilbor, surgeon of the Public Health Service, has been placed in charge. Any member of the military or naval forces of the United States of these states who needs such attention may come or be sent to the hospital for observation and diagnosis. The Hospital, which will start with 130 beds, has an allowance of \$85,000 for remodeling and other purposes. It will serve as a clearing house for the eighth district of the Public Health Service.

**PUBLIC HEALTH SERVICE COURSES FOR DIAGNOSIS OF TUBERCULOSIS.**—The Public Health Service, which for some time has been making special efforts to facilitate the diagnosis of tuberculosis, especially to bring about its recognition in the very earliest stages, recently opened mobile training courses for the purpose in Illinois, Wisconsin, Michigan and Washington. Similar courses have already been given in Texas, Louisiana, Missouri, Virginia, West Virginia, Maryland and Pennsylvania. The courses last seven days and are very intensive. They are at present open only to physicians attached to the public health service, but it is contemplated later on to hold similar courses for other physicians who care to attend.

**NO PAPER FAMINE IN FINLAND.**—With America suffering from a white paper famine it will be interesting to note the condition of the Finnish paper industry. According to reports from the American Red Cross workers in that field there were exported from Finland in 1919, 46,000 metric tons of paper, in spite of the fact that export trade was impossible for eight months, owing to shipping restrictions in Europe. The total export of paper mill products in 1919 was 200,451 metric tons, which included wood pulp, cellulose and cardboard in addition to white paper. Virtually all of this amount was supplied to fifty of the largest periodicals in England.

GOATS' MILK AND ROSE LEAVES FOR ICE-CREAM.—Ice-cream made of goats' milk and flavored with rose leaves is the leading delicacy of Greece and Crete, according to an American Red Cross worker who recently returned from abroad. Goats' milk is whiter than cows' milk and ice-cream frozen from it has almost the blue tinge of skimmed milk, unless colored with rose leaves. It has a peculiar flavor, but has no peer in the opinion of the citizens of Mitylene.

AMERICAN PUBLIC HEALTH ASSOCIATION MEETING.—The forty-ninth annual meeting of this association was held in San Francisco September 15, at which time the following officers were elected to serve during 1921: President, Dr. Mazycke P. Ravenel, professor of preventive medicine, University of Missouri; vice-presidents, Dr. Theodore Bruce Beatty, Salt Lake City, Dr. Louis I. Dublin, New York City, Dr. William C. Hassler, San Francisco, and Dr. Roger I. Lee, Boston; secretary, Mr. A. W. Hedrich, Boston.

COMMITTEE APPOINTED BY TUBERCULOSIS SOCIETY.—A medical advisory committee for the purpose of coordinating the efforts of medical practitioners and institutions for the control of tuberculosis has been appointed by the St. Louis, Mo. Tuberculosis Society.

DRUG TRAFFIC DECREASING.—A report from Chicago states that there are fewer drug addicts in that city at present than at any other time during the last three years. The statement was made by Dr. Samuel A. Braun, chief of the federal anti-narcotic squad, and is ascribed to the vigorous enforcement of the Harrison law.

SOCIAL SERVICE COURSE.—The University of Chicago has instituted a graduate school of social service administration, which began with the autumn quarter, October 1. Elementary, intermediate and full graduate courses are being offered to nurses, social workers and all others interested in social service. Two extension courses on related subjects will also be given.

NEW GERMAN UNIVERSITY.—According to a note in the *Paris Médical* a new University has been established at Cologne; the University of Bonn has been enlarged, and new departments have been added to several other universities of Germany.

UNIVERSITY OF PARIS TO ESTABLISH INSTITUTE OF PSYCHOLOGY.—The University of Paris associated with the *Facultés des Lettres et des Sciences* will establish at the University a psychological institute. The council of directors will be composed of professors H. Delacrois, G. Dumas, P. Janet, H. Piéron and E. Rabaud. Practical and theoretical teaching of all branches of psychology—physiological, experimental, pathological, comparative, and general, will be undertaken by the institute, and research can be carried out in the laboratories in preparation for university degrees. Two terms will comprise the diploma course.

MEDICAL SCHOOL PROJECT ABANDONED.—The China Medical Board of the Rockefeller Foundation has abandoned its project of establishing a medical school at Shanghai, China. The unexpected high cost of all the Board's undertakings in China was given as the reason for the change. It was stated that the Peking Union Medical College alone cost larger sums than in 1914 was thought would be necessary for both schools. Also, the capacity of the Peking school has not been reached.

CONGRESS OF PATHOLOGY.—In April, 1921, at Rome, under the presidency of Professor E. Perroncito, will be held the second international congress of pathology, which was scheduled to take place in 1914. The preliminary program announces among the subjects for discussion as influenza of man and animals, cancer and sarcoma, rabies and results of the Pasteurian vaccination, plague among ruminants, chicken pest, bee pest, scabies of man and animals and nerve regeneration. Pathologists and others who wish to attend the congress should communicate with Professor Mario Levi della Vida, the general secretary, at 58, Viâ Palermo, Rome.

POST-GRADUATE COURSE IN VENEREAL DISEASES.—The London Royal Free Hospital School of Medicine for Women will give a post-graduate course of instruction in the treatment of venereal diseases. It will begin on September 13, and conclude September 25, and has been arranged for the advantage of qualified medical women. The Elizabeth Garrett Anderson Hospital and the London Lock Hospital are interested in the project.

FIRST AID ON PULLMANS.—The Pullman car service is giving the American Red Cross First Aid training to the entire force



of colored maids employed on the transcontinental trains. Several of the women have already finished the course and now carry as part of their equipment the regulation First Aid Kit. The Pullman company has arranged with the New York Chapter of the Red Cross to give the course of training in First Aid and Home Hygiene to some hundreds of maids reporting to its New York terminal.

REPORTS OF CANCER IN SWITZERLAND.—Commenting on a recent compilation of cancer in Switzerland, the *Deutsche medizinische Wochenschrift* states that cancer is so prevalent in that country every twelfth person beyond 35 years of age faces the prospect of dying a victim of the disease. A recent five year period showed that gastric cancer formed 37.9 per cent., of the total; cancer of the female genitals 16.1 per cent., and mammary cancer, 10.6 per cent. A little less than five months was the average survival of the operative mammary cancer cases.

PLAGUE RESEARCH STATION.—The U. S. Public Health Service recently established at Pensacola, Fla., a research station for the study of bubonic plague. Additional trained experts have been detailed to cooperate with those already stationed there, and an increase in research equipment to facilitate investigations will be provided.

MALARIA REDUCED.—According to Dr. Oscar Dowling, president of the Louisiana State Board of Health, malaria has been reduced 50 per cent at Mound during the current year. This is a direct result of the work done there by health officers under the direction of the state board of health and the International Health Board. Mosquitoes, it is reported, have been reduced 87 per cent. in the houses in that vicinity.

INFANTILE PARALYSIS IN MARYLAND.—Dr. Samuel M. Wagon, of Hagerstown, Maryland, Health officer of Washington County, reports five cases of infantile paralysis within the last few months. The last case was discovered near Big Pool.

CIVIL SERVICE EXAMINATIONS.—The United States Civil Service Commission announces open competitive examinations for the following positions: Assistant Field Agent, Protective Social Measures, November 17; Director of Bureau, Division, or Section

of Protective Social Measures; Supervisor of Protective Social Measures; Field Agent, Protective Social Measures; Special Assistant Agent, Protective Social Measures November 23. Applicants should at once write for Form, stating the title of examination desired, to the Civil Service Commission, Washington, D. C., or to the Secretary of the United States Civil Service Board in their district.

FLORIDA STATE BOARD OF HEALTH.—A new program recently adopted by the Florida State Board of Health provides for the carrying of the message of health directly to the homes of citizens, especially in the remote rural districts. Field directors, under the direction of an experienced director of rural sanitation will work simultaneously in adjoining counties. A campaign to correct any defects which may develop after a careful survey will follow.

WISCONSIN WILL HAVE NEW STATE HOSPITAL.—Plans have been submitted to the architect of the State of Wisconsin for the new State Hospital which will be erected on the University of Wisconsin campus. According to the plans, the new hospital when completed will include two groups of buildings, in addition to the first group, work on which will begin this year. The hospital when completed will have a capacity of 1000 beds.

PASSENGERS TO THE UNITED STATES TO BE VACCINATED.—The United States Public Health Service has issued orders to all officers in Europe not to permit any third class passengers to depart for this country without first being vaccinated for smallpox. Dr. Rupert Blue at present in Paris will remain all winter to perfect the organization of the health service. Offices will be maintained in every large port of Europe, in order to minimize the danger of smallpox, typhus, and other diseases being carried into this country.

MEETING AMERICAN ELECTROTHERAPEUTIC ASSOCIATION.—The thirteenth annual meeting of this association was held in Atlantic City, Sept. 14-17, and the following officers elected for the ensuing year: President, Dr. Byron Sprague Price, New York City; vice-presidents, Dr. Virgil C. Kinney, Wellsville, N. Y.; Dr. C. M. Sampson, M. C., U. S. A.; Dr. Charles Collins, Washington, D. C.;

Dr. Douglas A. Carter, East Orange, N. J.; Dr. W. T. Johnson, Philadelphia; trustees, Dr. Frank B. Granger, Boston; Dr. Frederick H. Morse, Boston; Dr. W. M. Clark, Philadelphia; Dr. E. C. Titus, New York; Dr. William Martin, Atlantic City; Dr. Frederic de Kraft, New York; secretary and registrar, Dr. A. Bern Hirsh, New York City; treasurer, Dr. J. Willard Travell, New York City.

THERE will be a regular meeting of the Fourth District Medical Society of Louisiana, in Shreveport, Tuesday, November 9th, at 2 P. M. There will be an afternoon and evening session, followed by a luncheon. The Secretary of that organization anticipates a very large attendance.

A CALLED meeting of the House of Delegates of the American Medical Association has been set for November 11th and 12th, 1920, for the purpose of amending some special feature of the By-Laws of the American Medical Association which they were not able to attend to at the last annual meeting.

THE American Medical Association has called a meeting of the State Secretaries of the various State Medical Societies to convene in Chicago, November 11th and 12th, 1920, at which time various matters concerning the State Medical Societies' activities and in relation to the American Medical Association will be considered.

PERSONALS.—The following doctors have returned from their vacations and resumed practice since our last report: O. C. Cassegrain, F. E. Lamothe, F. A. Overbay, John B. Elliott, Jr., W. D. Phillips, A. A. Pray, J. J. Ryan, W. H. Harris, G. K. Logan, E. S. Scharff, Elizabeth Bass.

Dr. E. D. Martin, has resumed practice after an illness of a few weeks.

Dr. Seale Harris, of Birmingham, Ala., announces the opening of his Dietetic Institute, a private infirmary for the diagnosis and the dietetic and medical treatment of diseases of the stomach and intestines and of nutrition.

REMOVALS.—Dr. E. S. Hatch, from 1126 Maison Blanche Building to 3439 Prytania St.

Dr. A. A. Keller, from 1210 Maison Blanche Building to 4909 Danneel St.

Dr. L. R. DeBuys, from 1122 Maison Blanche Building to 3439 St. Charles Ave.

Dr. P. Michinard, from 726 Maison Blanche Building Annex, to 701 Canal Bank Annex Building.

Dr. B. R. Heninger, from Maison Blanche Building to 3439 Prytania St.

Dr. J. B. Ferran, Jr., from 702 Macheca Building to 930 North Broad St.

Dr. J. M. Funderburk, from Clarks, La., to Winnsboro, La.

Dr. Clarence Pierson, from Jackson, La. to Alexandria, La.

Dr. F. R. Gomila, from 504 to 516 Macheca Building.

Dr. S. F. Braud, from 4828 Prytania St. to 1322 Josephine St.

*Southwest Journal of Medicine and Surgery*, from El Reno, Okla., to 308 Continental Building, Oklahoma City, Okla.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

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### BOOK REVIEWS.

**The Treatment of Syphilis.** By H. Sheridan Baketel, A. M., M. D. The Macmillan Co., New York, 1920.

The book could well have been called "The Treatment of Syphilis with Arsphenamine," as at least two-thirds of its contents are devoted to the different phases of this form of treatment. Considered as such, it is both an interesting and instructive work, as it gives a complete history of the new arsenicals and careful directions for their use. The title seems to the reviewer too comprehensive as so little space is allowed to the other two of the generally recognized triad for the treatment of syphilis. Making due allowance for personal preferences, the state of our knowledge today does not justify the scant recognition allowed to mercury and iodine.

A few slips should be corrected in a future edition, such as the reference to "a renal nephritis," and the author's enthusiasm for arsphenamine might be restrained sufficiently to permit the withdrawal of the statement, in reference to the administration of thirty grains a



day of iodid of potassium, "there is no more advantage of putting this amount into the patient's stomach than into his shoe." No doubt much larger doses are useful and often necessary, but too many of us have seen the effect of the amount mentioned to be able to let the assertion pass unchallenged. It is all right to be enthusiastic about new friends, but we need not break with the old. C. C.

**Sexual Impotence.** By Victor G. Veeki, M. D. W. B. Saunders Co., Philadelphia and London, 1920.

Having reviewed previous editions of this little book, upon which we look with much favor, we can only repeat our commendations and call attention to the significant sign of its appreciation by the medical profession—the fact of this being its sixth edition. If we wanted to pick flaws at this late date, we might venture to suggest that a rearrangement in the nature of simplification of the forms or classes of impotence would be an improvement.

Taken all in all, however, the volume is so full of meat and displays so advantageously the experience and good sense of its author that it is a pleasure to re-read it and to recommend it to those who have not yet enjoyed it. C. C.

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## PUBLICATIONS RECEIVED

**WILLIAM WOOD & CO.,** New York.

Cunningham's Manual of Practical Anatomy, Seventh edition, Vol. 3, Head & Neck, Revised and edited by Arthur Robinson.

**W. B. SAUNDERS COMPANY,** Philadelphia & London.

Surgical Clinics of Chicago, Vol. 4, No. 4, August, 1920.

**WASHINGTON GOVERNMENT PRINTING OFFICE,** Washington, D. C.

Manual for the Various Agents of the United States Interdepartmental Social Hygiene Board.

U. S. Department of Agriculture, Service and Regulatory Announcements. Supplement. Notices of Judgment Under the Food and Drugs Act. August 31, September 3, 13, 24.

Public Health Reports, Volume 34, Part 2, Numbers 27-52, July-December, 1919.

Public Health Reports, Volume 35, Nos. 35, 36, 37, 38, 39.

### MISCELLANEOUS.

Massage and Exercises Combined, by Albrecht Jensen. Brooks & Porter, New York.

Vaccination in the Tropics, by W. G. King, C. I. E. Tropical Diseases Bureau, London.

English Atrocities in Ireland, by Katherine Hughes.

Twenty-ninth and Thirtieth Annual Reports of the Eye, Ear, Nose and Throat Hospital of New Orleans.

### REPRINTS.

On the Treatment of Some of the Forms of Cardiac Failure, by Lewellys F. Barker, M. D.

## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for August, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	5	2	7
Intermittent Fever (Malarial Cachexia)			
Smallpox	2	1	3
Measles	1		1
Scarlet Fever			
Whooping Cough			
Diphtheria and Croup	1	1	2
Influenza			
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	31	27	58
Cancer	21	9	30
Rheumatism and Gout			
Diabetes	7		7
Alcoholism	1		1
Encephalitis and Meningitis	3	1	4
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	20	8	28
Paralysis	1		1
Convulsions of Infancy	2		2
Other Diseases of Infancy	9	4	13
Tetanus		1	1
Other Nervous Diseases	5	1	6
Heart Diseases	44	20	64
Bronchitis	2	3	5
Pneumonia and Broncho-Pneumonia	9	11	20
Other Respiratory Diseases		2	2
Ulcer of Stomach			
Other Diseases of the Stomach	2	2	4
Diarrhea, Dysentery and Enteritis	9	8	17
Hernia, Intestinal Obstruction	16	2	18
Cirrhosis of Liver			
Other Diseases of the Liver	3	1	4
Simple Peritonitis			
Appendicitis	7	3	10
Bright's Disease	14	8	22
Other Genito-Urinary Diseases	11	15	26
Puerperal Diseases	9	4	13
Senile Debility	2	1	3
Suicide	4		4
Injuries	30	12	42
All Other Causes	21	20	41
TOTAL	293	167	460

City of New Orleans, for September, 1920.

Still-born Children—White, 25; colored, 25; total, 50.

Population of City (estimated)—White, 290,000; colored, 110,000;

Death Rate per 1000 per annum for Month—White, 12.13; colored,

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

18.22; total, 13.80. Non-residents excluded, 11.40.

Mean atmospheric pressure..... 29.96

Mean temperature..... 82

otal precipitation..... 6.47 inches

Prevailing direction of wind, southwest.

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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**EDITOR:** CHAS. CHASSAIGNAC, M. D.

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## **EDITORIAL**

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### **TO STATE AND CITY SOCIETY MEMBERS.**

Outside of actual financial ownership, this JOURNAL is really that of the Louisiana State Medical Society and its component societies, especially the Orleans Parish Medical Society. We publish by agreement, all the papers furnished by the societies; we have proposed to allow any reasonable amount of the space to them for use in communicating with their members, in their own way; the JOURNAL is furnished regularly and promptly to all its members, according to lists furnished by the societies—and all this is done at a very low cost to them.

We believe we have faithfully carried out our part of the proposition for many years; we have backed up the societies in their energies and endeavors and, having no complaint to make on our part, we consider we are in a good position to ask whether our

medical bodies have taken full advantage of their opportunities in the publicity line.

We fear not. We feel that more can be done to make this publication the live organ of our medical bodies. We would want to help more in keeping the members in touch, have them ask and receive more information about medical matters in general and society matters in particular; in fact, do all in our power to develop a proper *esprit de corps*, stimulate better organization, foster the scientific spirit as well as protect the physical welfare of our physicians.

Co-operation is necessary in order to attain the end we have in view. Neither side can do it all, so stir up your officers and committees and put us on our mettle to hold our end of the line. Team-work can accomplish wonders and it is our earnest desire to accomplish our part therein.

In wishing you a merry Christmas, permit us at the same time to urge you not only to prepare your good resolutions for next year, but, especially, to arrange to carry them out in earnest.

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#### VICE-PRESIDENCY OF THE A. M. A.

At a meeting of the Trustees of the American Medical Association, held recently in Chicago, our distinguished confrere and collaborator, Dr. Rudolph Matas, of this city, was elected vice-president of the Association to succeed our lamented Dr. Dyer. In thus honoring itself the Association has at the same time complimented the South, Louisiana and Tulane.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### SOME OF THE MOST PROBABLE CAUSES OF MENTAL DISEASES.\*

By DR. C. V. UNSWORTH.

As you well know, the existence of a mental disease affects the position of life of an individual more than any other disease and the State and Society have more direct control of them than any other class except the criminal, when you consider the powers the law gives a physician to sign a certificate that deprives him or her of their liberty or civil rights. Surely such a responsibility implies an obligation on the part of a physician to know something of mental diseases and their causes.

As in all other branches of medicine, you find two distinct classes as to the causes of mental diseases—predisposing and exciting. The predisposing causes are subdivided into heredity and acquired. General causes are age, sex, civil condition, climatic and exhaustive diseases. Exciting causes are sub-divided into toxic, infectious, traumatic and bodily diseases. The predisposing causes are those that are in an individual's make-up, which renders him liable to the development of the psychosis under favorable conditions. In other words, to develop something that has been lying dormant since birth. The exciting causes are those conditions which produce the actual attack of mental disturbance, acting upon favorable soil.

An inherited predisposition is found in about 85% of all cases, although you will find very frequently given as a cause of an attack such as "she was disappointed in love"—"death of a near relative"— or "financial losses," etc., but when, as a matter of fact, you take a correct history, you will find these are only exciting causes and the real cause would be predisposing, that is, by heredity.

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\* Read before the Orleans Parish Medical Society, October 25, 1920. Symposium on Mental Disorders.

We have all, no doubt, some time in our lives, had some of the exciting causes—still sanity is the rule and insanity the exception. In other words, the normal mind, under the influence of stress, does not develop a psychosis, unless from traumatism.

Toxemia or some great degree of exhaustion even then will not act with the same readiness as you find in a predisposition by heredity.

That intermarriage of near relatives is the cause of a psychosis has been demonstrated to be incorrect. It is only when there is a bad strain in the family which would naturally intensify the predisposition. First cousins with a good family history can have healthy children.

Acquired predisposition. The most important agencies producing this acquired predisposition are alcohol, syphilis and tuberculosis. Tuberculosis by its prolonged toxic condition, acting on a normal brain, would predispose it to disease and thus produce a psychosis.

General causes, such as age, frequently act. The greatest liability is between the ages of 18 and 45.

As regards sex—Although the psychoses are equally divided between the males and females, especially dangerous periods with the females are the puerperium and the climacterium. This is balanced by syphilis and alcohol to the more strenuous life of the male.

Climate. The climate has no direct influence except to supply conditions which make exhaustion and infection more liable.

Exciting causes, such as the various poisons, may produce a psychosis. These causes may originate within the body or enter it from without. Among the latter, syphilis and alcohol are responsible for about 30% of the mental diseases in the male. Some of the other poisons which belong with this group are morphine, cocaine, alcohol, etc. The toxemias of various diseases may act as exciting causes, such as those of the gastro-intestinal tract, chronic nephritis and most probably, pellagra.

Exhaustion from prolonged physical or mental strain, or as a result of an acute condition following fever, or the loss of a quantity of blood, sudden shock, injuries to the head, such as fractures and concussions furnish exciting causes for psychoses.

Very often mental diseases result from various causes of which the superficial observer perceives the most prominent. Careful

observers do not make this error, although in cases where several causes are associated it is difficult to appreciate how much each has contributed to the result. When you do not know how a particular morbid process has developed, a study of the symptoms enables you to trace by analogy the special cause that has produced it.

There are some psychoses clinically similar, which depend upon the more or less changeable—

Accident of external circumstances. In these cases, environmental influences constitute a condition if not sufficient to at least a necessary cause for the diseases.

There are other psychoses similar to each other in their symptoms, which arise only under the impulse of an intense predisposition. Between these two extremes there is an ill defined series of mental diseases which are brought about by mixed causes. These act in various ways in different individuals, notwithstanding the close similarity of the morbid pictures so that unless you are able to get an accurate personal history, it is impossible to know whether the patient is a victim of his environment, of his special constitution, or of both influences combined.

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## DEMENTIA PRAECOX.\*

By E. McC. CONNELLY, Surgeon (R.) U. S. P. H. S., Adjunct Prof. of Psychiatry,  
Loyola University.

Dementia Praecox has been the subject of a great deal of investigation, more, I should say, than any other psychosis, and almost as many theories as to its exact nature have been advanced as there have been investigators.

It is characterized by an early, rapidly progressing dementia, and as the name implies, it is essentially a disease of early life. However, this is not invariably true, for cases are encountered in which no other diagnosis is possible, where the onset comes as late as fifty years. Owing to this fact, Bleuler has suggested the term "Schizophrenia," implying a splitting of the personality, which he holds as the most prominent symptom.

Its etiology is open to discussion—heredity certainly plays a

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\* Read before the Orleans Parish Medical Society, October 25, 1920. Symposium on Mental Disorders.

prominent part. Wolfsohn was able to demonstrate a psychotic taint in ninety per cent of a series of 647 cases, mental diseases, nervous diseases, and alcoholism being the most prominent factors. Kraepelin has conceived it to be the result of an auto-intoxication, with the toxic factor an internal secretion of some gland—probably the ovary or testicle as its occurrence is so closely related to puberty and adolescence. Again, Adolf Meyer considers it the result of continued unhealthy biological reactions due to an inability to adjust. These reactions occur in persons of a “shut-in” make-up; people, who do not meet difficulties openly and frankly, but who avoid issues by fault finding and temporizing in various ways. Their relation to the outside world is unnatural, they are seclusive, inclined to be over-scrupulous, prudish and do not discuss their problems with others.

Sufficient study will reveal some exciting cause in a large majority of cases. In fact, we are all familiar with the histories given by relatives, in which the responsibility is placed upon over work in school, or upon some mental or physical trauma.

Mentally, the praecox seems entirely apart from his surroundings, he has completely withdrawn into himself, and is absolutely out of touch with the outside world. He does not, as a rule, associate with other patients—is occupied with his own thoughts, and takes no notice of events about him. This latter condition is due in a large measure to his lack of concentration. There is a marked disturbance of the emotional reaction, characterized by in-coordination and changes in affectivity,—he will laugh when he should cry, and cry when he should laugh; or he will smile in a simpering manner under circumstances that would require a hearty laugh. Indifference is an early and prominent symptom of this emotional deterioration. The absence of initiative is evidence of the lack of continuity of thought. He is utterly incapable of amusing himself, never institutes an action, and seldom completes a task of his own volition. The sluggish association of ideas and the shallow thought content is manifest by incoherence in speech. This ranges from the rambling of the early stages to the “Word Salad” of the advanced dement. Hallucinations, usually auditory, and delusions, play a most prominent part in the symptomatology. The delusions are fantastic and absurd in type, and the patient makes no effort to justify them with reason. He will state that he has no stomach, that his throat is closed, but continues to eat. The loss of memory



and disorientation is more apparent than real, as, owing to his lack of attention, many events are not registered in his mind, consequently his failure to recall them does not constitute a loss of memory, he never possessed them.

Physical signs play a small part in the symptomatology. In the early stages, headaches, vertigo, gastric disturbances, and other hysterical symptoms are often manifest, and there is, as a rule, inanition, anorexia, rapid heart action and cyanosis of extremities with other evidences of vaso-motor disturbances.

The mode of onset varies greatly; it may be insidious and extend over years, again it may be abrupt and the patient will suddenly display evidence of psychosis after some severe mental or physical trauma.

In describing *Praecox*, authorities vary as to the types. However, four are usually recognized, viz: the Simple, Hebephrenic, Catatonic and the Paranoid.

In Simple *Praecox*, the onset is gradual and it is usually impossible to fix its date as the first symptoms are seldom recognized.

The patient who had previously been bright and industrious in his studies and who had taken an active part in his school life is gradually changed. He loses interest, becomes indifferent, careless, indolent and is apparently unable to learn. He is seclusive, maintains a listless attitude, displays a certain irritability, and at times is depressed. Unsystematized delusions and fleeting hallucinations, usually of a disagreeable nature, occur. Physically, he complains of headaches, insomnia, and displays hysterical symptoms which frequently lead to the diagnosis of neurasthenia.

The Hebephrenic, or silly type, is more acute, although it is usually preceded for some time by prodromal symptoms.

In the early stages there is insomnia, irritability, loss of appetite, headache, and restlessness, which may amount at times to excitement and violence. Depression is quite marked and attempts at suicide are frequent, delusions and hallucinations, which are fleeting and of an unpleasant character, appear. As the acute symptoms subside, the deterioration becomes more apparent. The attitude is dull, listless, and apathetic; the delusions vary, are fantastic, silly and absurd, and no attempt is made to justify them. The hallucinations are changeable and disagreeable. The patient is seclusive, preoccupied, and indifferent; emotional deterioration is marked, and he will discuss in the most phlegmatic manner the

people who are threatening to kill him, who are accusing him of horrible crimes or calling him vile names. Speech is incoherent and disconnected. At times, periods of activity may vary this apathetic attitude.

The catatonic phase is more apt to begin abruptly than the other types of praecox, but it too, generally, is preceded by prodromes. It is divided into catatonic stupor and catatonic excitement.

In the stuporous stage the outstanding features are muscular tension, negativism and stupor. The patient will remain rigidly in one position and efforts to move his limbs disclose the tenseness of the muscles. He is absolutely mute, and takes no notice, whatever, of happenings about him—he may be thoroughly cognizant of what is going on, however. Sensory stimulation elicits no response. If he is told to open his eyes, or an attempt is made to open them, he closes them tightly, and vice versa. This negativism extends, even to his own wants—he refuses to eat or to attend to the calls of nature, and will allow the bladder and rectum to become overloaded, or saliva to accumulate in his mouth until it is fetid. As the reverse to this picture, we have in place of muscular tension, “waxy flexibility” and suggestibility instead of negativism. The patient will maintain any position in which his limbs are placed, no matter how uncomfortable it may be; or he will repeat phrases and perform actions commanded, in an automatic, mechanical manner.

Catatonic excitement alternates with catatonic stupor. In it, there is marked excitement and greatly increased psychomotor activity, but the actions are not directed towards any definite end, and impulsive acts are characteristic—the patient will smash a window, attack another patient, or attempt suicide without apparent reason, nor will he be able to give any, when questioned. He is very noisy and will shout a senseless jargon at the top of his voice. Hallucinations do not play any apparent part in these actions. Quieter periods, in which mannerisms and stereotyped movements are developed, interrupt these outbreaks of violence.

In the Paranoid form a much more systemized delusional state is presented—the onset is slow, and mental deterioration is more gradual than in the other forms.

The prognosis of Dementia Praecox is at best guarded. A considerable number of cases have remissions during which they adjust sufficiently to care for themselves outside of an institution, but

they do not completely regain their former mentality, and all, are apt to have recurrences. The Catatonics have the best prognosis; **the Hebephrenic and Simple types** tend towards progressive deterioration, and the Paranoid is apt to remain more or less stationary.

In the well developed and typical forms of praecox, the diagnosis is a comparatively simple matter; however, there are many typical cases in which it is most difficult, and can only be established after long observation and a thorough history has been obtained. It is based upon the early and rapidly progressing deterioration; the loss of touch with the outside world; the indifferent attitude; the lack of coordination in the emotional reaction; and the lack of continuity and shallowness of thought.

The physical treatment is largely symptomatic—the nourishment should be kept up, the elimination carefully watched, the mouth cared for and the bladder and rectum should not be allowed to become overloaded. The excitement is best controlled by hydrotherapy in the form of continuous baths or packs. Physical and chemical restraint should always be avoided if possible. The psychic treatment consists of efforts to gain and direct the patient's attention and to arouse his interest by occupational therapy and he should be analyzed carefully for his complexes in order that they may be adjusted as far as possible.

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## CLINICAL VERSUS LABORATORY FINDINGS IN SYPHILIS OF THE NERVOUS SYSTEM.\*

By DR. C. S. HOLBROOK.

There is no field in medicine where the importance of a correct and prompt diagnosis is more desirable than in syphilis of the nervous system and such a diagnosis is frequently not readily made. It has well been said that syphilis may mimic any disease of the nervous system and that the typical syndromes described in text books are seldom found and are valuable only in the descriptive art. In the study of a person with nervous or mental symptoms assistance should be sought from all sources. The family history, the personal his-

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\* Read before the Orleans Parish Medical Society, October 25, 1920. Symposium on Mental Disorders.

tory and habits of the patient together with the clinical findings should be thoroughly scrutinized. Frequently further information is desirable and it is here that the laboratory comes to our aid.

Greater progress has been made in developing laboratory tests to help in the diagnosis of syphilitic disease during the last fifteen years than in the preceding like number of centuries. Schaudinn in 1905 discovered the *treponema pallida*, Wassermann shortly afterwards applied the complement fixation test to the investigations of lues and finally Moore and Noguchi demonstrated the *treponema pallida* in the brain of paretics—thus closing forever the controversy that had waged over the question of the etiology of general paralysis of the insane. The laboratory is now so important that no thorough investigation of disease processes can be made in any branch of medicine without calling upon it for aid.

It is regrettable, but quite true, that the physicians of this day and time, as a rule, have not developed the acumen of diagnosis that is exhibited by those who were trained before the laboratories had taken such a prominent place in the study of morbid conditions. Many of the laboratory tests are quite reliable hence are methods of precision, and as such, their importance cannot be overated. The danger is that the signs and symptoms in the patient are not thoroughly studied and that too great dependance is placed upon the results of certain tests.

To return to diseases of the nervous system, I wish to reiterate that here syphilis presents itself by innumerable manifestations and that the *treponema* displays itself before us in all conceivable disguises. Many of the more or less atypical cases of paresis, tabes and meningitic luetic infections have been allowed to progress for months and years not because these diseases were not considered but because some laboratory tests proved negative. As a matter of fact, the blood Wassermann is of such little value in syphilis of the nervous system that a negative reaction should receive little consideration and a positive reaction means that the disease may be due to syphilis or that it is present in a syphilitic. A fairly large per cent of tabetics will give a negative blood Wassermann and the percentage is only slightly less in other forms of syphilis of the nervous system. To help these patients to the fullest extent we must recognize the malady in the early stages and treat the infection energetically. After marked ataxia, incontinence of urine and feces, etc. have developed



in a patient there is no difficulty or credit in diagnosing tabes for the disease should have been recognized from two to ten years earlier and the process arrested by properly directed treatment. Usually an erroneous diagnosis is made because the physician is thrown off his guard by the finding of a negative Wassermann in the blood.

Usually in syphilis of the nervous system distinct changes in the spinal fluid will be found. There are four tests that are of value, the cell count, globulin content, colloidal gold test and Wassermann reaction. All of these tests should be made in each examination for, not infrequently, it is found that one or two of the tests are negative while the others point to syphilis. The Wassermann may be negative with the cells and globulin increased and reduction in the colloidal gold or the reverse may be true—in fact almost any combination of results may be present. The laboratory investigation of the spinal fluid does not always rule out syphilis. In rare instances the blood and spinal fluid are negative to all tests and yet the patient is suffering from syphilis. Recently a negro man came to the Touro clinic presenting very typical symptoms of paresis and the blood and spinal fluid showed nothing abnormal to any of the tests. There is no doubt in my mind that this patient is afflicted with syphilis and such a diagnosis was made in spite of the laboratory returning negative findings.

A patient with syphilitic involvement of the meninges and the medullary portion of the brain is under my care. After moderately intensive treatment with salvarsan and mercurial rubs over a period of four months or so his spinal fluid which had at first been positive to the usual tests became quite negative to the same tests and the patient was allowed to go home, where mercury and iodides were given continuously but in smaller doses. After two months some symptoms appeared so he returned. Examination shows that the Wassermann was still negative in the blood and spinal fluid but the cells, globulin and colloidal gold pointed to a reawakening of the syphilitic process. Such experiences are not at all unusual and should teach us that a patient who has suffered from syphilis of the nervous system and in whom all the laboratory findings became negative not should be discharged as cured, but observation and frequent tests should be made of the blood and spinal fluid for several years at least.

When a person presents himself and gives rather vague symptoms,

especially of the so-called neurasthenic type and in whom a history of a venereal sore can be elicited, it is very important that syphilis be ruled out as far as possible, by an examination of the spinal fluid. It is only by such measures that the early cases of syphilis of the brain can be detected. Also any person showing Argyll-Robertson pupils should be considered as suffering from cerebro-spinal syphilis until it is proved otherwise. Unequal, irregular, slowly reacting pupils, absent or unequal patella reflexes should also place one on his guard.

In conclusion, I wish to make the appeal that the patient presenting nervous and mental symptoms be thoroughly investigated with syphilis in mind. We should discipline ourselves to consider the clinical symptoms presented by the disease process of prime importance though the laboratory with all other measures should be used to help clarify the diagnostic fog, but we must not be led astray by a laboratory report that conflicts with the symptoms presented by the patient. The clinical findings should always be of primary importance and the laboratory only of secondary importance. It is well known that in this particular field of medicine a negative blood Wassermann means very little but the findings in the spinal fluid are of great importance, though, even here, the results may not coincide with the clinical signs and symptoms. Before patients are considered cured of any form of syphilis the blood and spinal fluid should prove negative to laboratory examination and if at a previous examination the nervous system had showed involvement the patient must be observed over a number of years and the spinal fluid examined every few months. For a reasonable certainty of cure of syphilis of the nervous system it is necessary that the symptoms improve or at least remain stationary and that the laboratory findings of the blood and spinal fluid remain negative over a number of years. There are certain people who will continue to show positive laboratory findings after years of persistent treatment and these people are always problems and should be received with suspicion as far as a cure is concerned. Lastly I wish to express the importance of a complete laboratory examination in any patient who gives a history of a sore, especially if such a patient presents any nervous or mental symptoms.

**PARANOIA AND ALLIED PSYCHOSES.\***

By DR. W. J. OTIS

This is of necessity a very condensed presentation of the subject. Concepts associated with Paranoia have narrowed almost to the vanishing point. The word was used by the ancient Greeks to designate a kind of thinking that was beside itself, by Hippocrates termed Mad Delirious thinking. The term disappeared from use and reappeared in Psychiatry during the Middle Ages. Vogel in 1764 used it as a general term for Insanity; by Heinroth to signify intellectual confusion, the word was reintroduced fifty years ago as the name of a mental disorder characterized by "systematized delusions, usually of a persecutory or grandiose nature, in a person fairly clear. It was then synonymous with Primare Verruckheit, Wahnsinn, *délire chronique à evolution systematisée*, monomania, primary delusional insanity—terms which it has largely supplanted since Kahlbanum definitely used it in place of Primare Verruckheit in 1878.

Psychiatrists have differed largely however on many points, such as the relative importance of degree of systematization, chronicity, recoverability, dementia, presence of hallucinations or other symptoms, and also whether it was primarily an intellectual or an emotional disorder. The Freudian conception of this entity is that in the sexual development, a distinct homosexual stage is passed through. The homosexuality, however is not left behind in this process of development but the homosexual libido is sublimated, that is its energies are drafted into other channels such as for example social activities. Then follows the stage of Narcissism and a regression of the sublimated homosexuality to Narcissism. The libido of the Paranoiac is then projected upon those about him. That master of descriptive psychiatry, Kraepelin, in 1904 defined this entity as a condition in which delusions are the most prominent if not the only, symptom of the disease—these delusions of a chronic stable type develop without any disorder of the train of thought, of will or of action. These cases insidiously develop in a person of a psychopathic predisposition, a coherent, stable logically elaborated system of delusions of endogenous origin, with-

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out hallucinations, dissociations, negativisms, mannerisms, stereotypes, peculiarities of speech, neologisms—ideas of reference, emotional deterioration or dementia. The personality remains intact. These individuals are known for their keenness, shrewdness and argumentative ability. Among them are found lawyers, artists, musicians, mathematicians, and those with marked administrative ability. Paranoia is a rare psychosis, one per cent of all admissions to mental hospitals are from this disease. More common in men than women. The onset is between the ages of 22 and 40 years of age. Gradual as a rule.

The fundamental features of this Psychosis are:

The immutability of the basic fixed idea;

The absolute faith which the patient has in his delusion;

The apparent logic of the delusional system;

The promptness and intensity of the reactions;

The absence of hallucinations and the presence of numerous false interpretations and the absence of mental deterioration regardless of the time that the disease has lasted.

The first stage, that of subjective analysis, in which the patient becomes hypochondriacal, wrapped in self, unusual feelings occur, headaches, insomnia, he is restless and nervous; these, he fails to understand. Then follows depression, later ideas of reference present themselves. Here follow the delusions of persecution which sorely taunt him, and from which there is no apparent escape, everything about him directly or indirectly is suggestive of persecution.

The stage of the transformation of personality or second stage is now ushered in. The delusions of persecution are intensified. Misinterprets conversations heard. The actions of other persons are taken as antagonistic to him. The delusions are now almost constantly dwelt on to the exclusion of everything else.

Having attempted to escape through every known channels, these taunts, and persecutory activities, and having failed in obtaining redress from the civil authorities, as regards this continual system of persecution, he now attempts to defend himself. By his defense he becomes anti-social, thereby coming under the notice of the police.

Types allied to Paranoia are met with in other psychoses. For example the Paranoid Type of Dementia-Praecox, those in Paresis, the Toxic Psychoses. The paranoid personality of the constitutional psychopath, who is forever a source of annoyance to the public at



large and to himself, the paranoid conditions met with in criminals recently incarcerated.

Lastly those fleeting paranoid moments which we of the herd find ourselves entangled in from time to time, and by logical deductions, adjust themselves. The paranoid states in the allied psychoses adjust themselves as the patients react, whether it be recoverable or not.

There is no true pathology to paranoia. Records of cases dying of intercurrent diseases, late in life, show no definite changes that could be attributed to **paranoia**.

Quite recently Kraepelin has defined a comparatively small group of cases as Paraphrenias. These cases show a slighter development of disorder of emotion and volition, with the loss of inner unity essentially limited to certain intellectual faculties.

He names a Paraphrenia Systematica, characterized by the extremely insidious development of a continuously progressive delusion of persecution to which are added later ideas of exaltation without decay of personality, a Paraphrenia Expansiva characterized by the development of exuberant megalomania with predominantly exalted mood and slight excitement. The disease begins as a rule gradually, though at times sub-acutely.

Paraphrenia Confabulans, of which we find only a small number of cases in which pseudo-memories play the dominant role, these patients narrate extraordinary experiences in the sense of delusions of persecution and exaltation.

Lastly he defines a Paraphrenia Phantastica—Here we have a luxuriant growth of highly extraordinary, disconnected, changing delusions. The Paraphrenias rightly belong within the domain of Dementia-Praecox and are mentioned here solely as pertains to their Paranoid coloring. As to treatment of Paranoïa—those who are amenable to intelligent and well ordered discipline, and are able to remain at home, should be allowed to do so, for among these are many who are self supporting. Those who by their anti-social acts become a menace to the community should be placed in the proper hospitals.

As to prophylaxis—With a more comprehensive knowledge of the tenets of Mental Hygiene, and the hearty co-operation of all concerned, the physician could do much that would aid in the betterment of not only the Paranoïac, but all the mentally ill.

The poet, with great degree of insight, describes the Paranoiac as one who

“By sharp sensation wounded to the soul,  
 He ponders on the world; abhors the whole,  
 In the dire working of his wakeful dreams,  
 The human race a race of demons seems;  
 All is unjust, discordant and severe;  
 He asks not mercy's smile, nor pity's tear.”

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## SENILE PSYCHOSES.\*

By HENRY DASPIT, M. D.

Old age offers a fruitful and unfortunately a very neglected field for investigation. The tendency is all too prevalent for the greater bulk of the medical profession to regard the happenings, both psychic and physical, of advanced life with a fatalism which has its beginning in the mistaken presumption that, underlying this epoch, arterio-sclerotic change settles the question. We must recognize the fact that the pathology, physiology and certainly the psychology of the senile period is a study unto itself and offers problems and reaction types in no way dependent on arterial disease though quite naturally due note must be given the latter.

The modern psycho-analytic school takes the attitude that advanced age offers a definite barrier to psycho-analysis. While this may in a sense be true we must remember that many a personality has advanced through adolescence and adult life living in the borderland and keeping submerged and partly controlled a conflict which will crystallize during the senium into a frank psychosis. When one stops to consider the disillusionments which come with old age, with the lack of incentive to keep up life's battle and the frequent absence of properly diverting occupation, mental disorders may be expected to multiply.

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With many people the opportunity for perpetual self-contemplation and the development of faulty mental mechanisms, made possible by idleness, leads to mental disorders. It naturally becomes our duty long before the senile period to anticipate this and especially in handling the neurotic and predisposed individual to provide some occupation, pursuit, or even hobby which may be carried on far into involution. These interests thus begun and persistently encouraged would go far to stabilize the mental health in eliminating much of the irritability, peevishness and barren emptiness which is so conducive to mental disease in the aged.

Dercum very aptly expressed it in saying that, "There is a quantitative reduction, but this is limited in degree, so that the individual continues to discharge his functions normally to the end of life. It is only when this reduction is excessive, and especially when it is associated with qualitative changes, that it becomes pathologic."

A few of the more general evidences of intellectual denudation at this period would include memory defect, present even without any other impairment of mental activity and though dealing more particularly with recent events often sufficient to blot out entirely the remote past. Hand in hand with this naturally goes disturbance of impressibility, with the lack of ability to retain new impressions, with narrowing of the range of interests and impairment of the capacity for intellectual functioning. These limitations added to the lack of ability for sustained effort, whether appreciated or not by the individual, tend to the development of the narrowness, inflexibility, seclusiveness and egocentricity so often met with in the aged.

The hereditary factors, constitutional trends, result of past physical disease and intoxications (alcohol, etc.) need no comment as far as their bearing on senile psychosis is concerned. Suffice it to say that added to all factors exerting an influence throughout life in the development of mental disorders we must include the physical and psychic changes incident to the "involution of nutrition."

No attempt will be made to discuss the classic earlier psychoses which may extend into the senile period, or, as is frequently the case, make their first appearance at this time. In all of these conditions there will appear modifications of the typical picture de-

pendent on the altered physiology, pathology and mentalization of senescence.

In considering briefly the morbid mental states of old age, cerebral arterio-sclerosis should be taken as an entity, and while a certain amount of vascular disease may be found in the other conditions their being is not regarded as dependent on the sclerotic process. Difficulty may be experienced in differentiating senile dementia which is often complicated by more or less arterio-sclerosis.

The simple deteriorations beginning in the higher levels and advancing until the patient becomes childish, unable to attend to his own wants and requiring personal care though interesting in tracing their development cannot be discussed. Presbyophrenia as a sub-type of senile dementia, with its close surface resemblance to Korsakow's Psychosis, offers little difficulty unless the presbyophrenic may be excessively alcoholic.

Greater care than is usual should be exercised in the estimation of the confusional states which are all associated with evidence of memory defect with or without depression or elation. These confusions and even simple memory deficits are often transient and clear without residual defect. Many instances have come to my observation where these cases have been classed as classical Senile Dements, interdicted and kept for indefinite periods under institutional care. With others I have also been guilty of this error, but time has taught me that particularly in its early development senile dementia may assume variant forms and much care should be practiced before attaching a label which admits of no betterment.

The depressions of the period of revision with their associate anxiety and apprehensiveness in the vast majority do not form part of other psychoses. This group offers the most frequent of this period. The depression is of insidious onset, of a few weeks to one or two years duration and of fair prognosis. The exaggeration of personal trends, hypochondriacal ideas, introspection in addition to the feeling of indifference, inefficiency and depression tends to cause one to regard the condition as separate from the Manic Depressive group. This condition as well as profound melancholia which Savage so well calls "the saturated solution of grief" have no connection with the depressions which are associated with arterio-



sclerotic brain disease. The latter presenting evidence of focal lesion and dementia.

The paranoid state or, as better termed by Kraepelin, "Senile Delusion of Persecution," closely resembles simple paranoid except that the detail of the delusional content is inconstant, lacking in detail and frequently changing. The varying and bizarre composition of the complex reminds one of dementia praecox but the many essential factors of the praecox are absent. The condition begins in the early senile period. Its chronicity without material deterioration until quite late justifies its separation from senile dementia.

It is too early in our appreciation of the subject to consider central neuritis, though its incidence in advanced life has been well demonstrated.

The lesson in the above remarks, which in no way attempt to complete the survey of the subject, is that old age in all its phases calls for our more careful attention and that the influence of arterial sclerosis while of import in no sense offers but passing interest.

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### FEEBLEMINDEDNESS.\*

By DR. GEORGE F. ROELING.

With time limited, I will be brief and confine myself to the essential points on this subject. Until recently the literature on this subject has been very limited. At present quite voluminous.

*Feeble-mindedness is insanity* from arrest of cerebral development. The individual has always lacked something. In true insanity or dementia, the individual is deprived of the mentality he once enjoyed. The older works embodied the study of comparative anatomy and pathology. The modern studies embody psychological, clinical and pedagogical. Before the age of puberty, true insanity is rare. Feeble-mindedness is divided into classes according to clinical grade and according to pathology.

#### CLINICAL CLASSIFICATIONS ACCORDING TO GRADES.

*Idiots*—that is to say, persons so deeply defective in mind from birth or from an early age, as to be unable to guard themselves

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against common physical dangers. Usually unimproved by training.

*Imbeciles*—that is to say, persons in whose case there exist from birth or from an early age, mental defectiveness not amounting to idiocy yet so pronounced that they are incapable of managing themselves or their affairs or, in the case of children, of being taught to do so.

*Moral Imbecile*—that is to say, persons who from early age display some permanent defects, coupled with strong vicious or criminal tendencies on which punishment has had little or no effect.

*Feeble-mindedness*—that is to say, persons in whose case exist from birth or from an early age, mental defectiveness, not amounting to imbecility and yet so pronounced that they require care, supervision and control for their own protection and for the protection of others, or, in the case of children, that by reason of defectiveness appear to be incapable of receiving proper benefits from instruction in the ordinary school.

#### PATHOLOGICAL CLASSIFICATIONS.

There are two main divisions of cerebral abnormality:

1. That arising from formative or developmental defects called Primary Amentia. Mental defects due to intrinsic causes (morbid heredity).
2. That resulting from inflammatory or degenerative processes, called Secondary Amentia due to extrinsic causes (trauma, disease or other unfavorable environment).

Note:—90% are Primary Amentia.

Under the heading of developmental cases the following may be grouped:

1. Epiloia or Tuberos Sclerosis.
2. Eclampsic.
3. Epileptic.
4. Syphilitic (Inherited).
5. Paralytic.

Those due to defects of special areas and partial atrophies:

1. Microcephaly. 2. Hydrocephaly. 3. Hypotrophic. 4. Mongolian Idiot.

Under the heading of Accidental, Inflammatory or Degenerative may be grouped:

1. Traumatic.
2. Post-Febrile (Oxycephaly).
3. Emotional.
4. Toxic Amurotic (Family Idiocy).
5. Nutritional (Cretinism and Infantilism).
6. Sense deprivation.

#### HISTORICAL REVIEW.

Prior to the last eighty years, little or no attention was paid to the mentally deficient child. Since that time there has been a gradual progress, until in the last few years, this important subject began to attract attention. The first scientific work was begun in Paris, by Séguin, at the Bicêtre Hospital, having for his object the words of Esqurol (To remove the mark of the beast from the forehead of the idiot). Some efforts had been previously made by Itard, Esqurol, Voisin, and others. In 1801, the first account was published by Itard, whose report embodied the studies on a boy found running wild in the woods of Aveyron. In 1837, Séguin, an old scholar of Itard's, and Esqurol reported the results of instruction on an idiotic child. In 1842, Germany, Switzerland and France and some of the other countries of Europe took up independently the work of the mentally deficient children. In 1846, Séguin, published a book entitled; "Traitement moral, Hygiène et Education des Idiots et des autres Enfants Arriérés." This work can be regarded as the beginning of the emancipation of the imbecile class. In this country, Massachusetts was the first to take up the work of mentally deficient children, that was in the year 1848. They established an experimental school for the feeble-minded. In 1851, New York, established her experimental school. In 1853, Pennsylvania established a training school for the feeble-minded; Ohio, in 1857. Between the years of 1855 and 1865, Kentucky, Connecticut. and Illinois, established their institutions. These giving the nucleus for the work and the study of feeble-mindedness in this country. In 1898, report of the National Conferences of Charities and Corrections showed that there were twenty-four public institutions in 19 states and that the city of New York had its own. In 1912, report of the *American Philanthropic Journal* showed that all but 18 states in the union had made public residential provisions for their mentally deficient. The U. S. Bureau of Education showed that 99 cities had established private classes for their

mentally deficient and that 220 classes were formed for the mentally backward children. This is about all the data that could be collected upon this subject. This gives you an idea of the importance of this subject and the backwardness of our own state in the care of her unfortunate children.

#### ETIOLOGY.

The etiology of feeble-mindedness, imbecility and idiocy may be best considered under the following heads:

1. *Those Occurring Before Birth.* The prenatal causes are the most important. In over 50% of feeble-minded children the cause can be shown to be congenital. Most cases directly traceable to defective nervous system on part of the forbears, from families of distinct neurotic taint; the insane, the epileptic, the hysterical and the like. Idiotic or feeble-minded children are sure to issue. The chances are greater in consanguineous marriages, when neither side has a clear record. They are greater when feeble-mindedness is a parental stigma. Direct inheritance with perpetuation of type, is more frequent in idiocy than in any other degenerative condition. Alcohol stands prominent in the relationship to idiocy and feeble-mindedness. 2,554 patients admitted with idiocy, epilepsy and feeble-mindedness to the Bicêtre records show that in 45% of cases one or both parents were alcoholics. Syphilis and tuberculosis parentage give rise to gross lesions and are responsible for failure of development. The other prenatal causes are diseases and injuries affecting the mother during her pregnancy.

2. *Causes at Birth.* Are chiefly traumatic; during or just preceding delivery, the child's brain sustains injury. First children and boys are exposed to such dangers.

3. *Causes After Birth.* All pathogenic agencies, traumatic, toxic, or nutritional, cerebral, meningeal hemorrhages, meningitis, cerebro-spinal form chiefly, scarlet fever, typhoid, convulsions, chiefly those of epilepsy.

It must be remembered that the brain of an infant or child is an extremely delicate organ, and undergoes rapid development, so much so, that at the end of the second year, it weighs three times as much as it did at birth, so that one can see at a glance, that from the purely reflex character of its functions and quick response to stimuli an apparent trivial cause may arrest its development and with the rapid growth of the organ may have a far reaching effect.



## PATHOLOGY.

A child does not attain its full structural mental development until the fifteenth year of life, consequently the pathology on this subject is nothing more than the pathology of the brain in infancy and childhood and must embrace all the injurious influence which acts upon the brain until that period of life.

The lesions in idiocy are gross and microscopic. The microscopic changes are as a rule proportionate to the mental deficiency during life. There is a numerical deficiency in the number of cells. Irregular arrangement of cells. Imperfect development of the individual cells. A paucity of dendrons. The pyramidal layer of the cortex shows the obvious abnormalities. In its deep layer pigmentation is observed. There is a general diminution of nerve fibres. There is often a sclerosis or an overgrowth of neuroglia, usually in the form of localized patches. They are found chiefly in three situations; (1) In the gray matter of the cerebral cortex. (2) In the floor of the lateral ventricles. (3) The surface of the hemisphere under the pia mater closely applied to the cortex.

*Gross Pathology.* The gross lesions consist of tumors, areas of sclerosis, meningeal thickening defects of malformation. Thus, the cortical convolutions are absent or imperfectly developed, or the basal ganglia are absent. The corpus callosum totally deficient as are also both lobes in the cerebellum. These defects may be the result of agenesis or may have been caused by intracranial hemorrhage. In the event of hemorrhage large cysts are often found. The brain weighs less than a normal brain; skull usually thick and dense, non existing diploe, sutures prematurely united.

*Endocrine.* The sign of endocrine changes are found quite frequent, about 21% of cases showed a marked change in the glandular tissue. The pituitary has been found invaded more often than any other. The gonads affected in 38%, suprarenal, rarely; thyroid, frequently.

## SYMPTOMOLOGY.

The symptoms of mental arrest varies with the time when arrest occurs and in some way with the cause. In congenital cases the child is usually several months old before the mother notices that it is different from the other children. In acquired cases such as, for example, meningitis, the arrest is noticed consecutively to the cause.

The symptoms between the profound idiots, whose life is purely automatic and vegetative and the backward or feeble-minded children. The gap is too wide to permit a satisfactory description of symptoms which would hold good for both classes.

Between the two classes will be found many cases some which incline to one end of the scale; others to the other.

*Profound Idiocy.* These are Physical and Mental.

Cranial anomalies are the most constant. The skull is either too large or too small or asymmetrical; nose and ears have degenerative stigmata; lips thick and teeth defective. Nearly all are undersize; ill-proportioned and clumsy; all, are homely in ways; repulsive in appearance; they speak either indistinctly or not at all and they utter meaningless sounds; the saliva runs from the mouth; urine and feces are passed involuntarily, their attention can be attracted very little or not at all by sights and sounds. Pain sense is greatly diminished. They are nearly or entirely helpless, requiring to be fed and cared for in every way.

*Symptoms of Imbecility and Feeble-mindedness.* Some degenerative stigmata are present in the parents, or there was a history of difficult labor when the child was born or severe convulsions occurred in childhood. At birth the baby seemed normal, took his nourishment well or with little difficulty and increased in weight or only constant or slight loss of weight. The mother may have noticed about the sixth or eighth month that the baby was less playful than other babies; that it did not follow objects with its eyes. Its attention was difficult to attract. The child might pass into its second year without saying any words; slowness in learning to walk is the first thing that attracts parental attention.

In mild cases, the child passes through the period of infancy and is not noticed as backward until the school teacher reports slow progress and mentally inferior to its age.

In other cases, mental deficiency is established in direct sequence to an infectious disease and comes to an abrupt interruption of the previously normal progress. In such cases the child may lose much of the intelligence it had gained. In mild grades of feeble-mindedness, the instincts are not greatly different from what they are in health. Hunger is felt by all, is often indulged to point of gluttony. Some feeble-minded are polite and docile but a large number are rude and uncivil and are often difficult to train. They are

destructive in temperament. Feeble-mindedness is acutely sensitive to pain and pleasure. They are affectionate in certain measures but not to a point of self-sacrifice. They all appreciate kindness and repulse rough treatment to a point of unprovoked assaults. Most feeble-minded children are mischievous. Sleep is usually impaired; masturbation, common.

*Diagnosis.* The early diagnosis of idiocy and feeble-mindedness is important, chiefly from the point of view of education. It is very essential for the attainment of practical results that training begin early. The diagnosis as to the intellectual defect in the early months of infancy, if this defect is not profound, is practically impossible. There is so much physiological variation in normal development that slight irregularities, although they may excite the physician's suspicion, can not be relied upon as diagnostic. The normal development of the infant at varying periods can be found in different works on child study, notably that of Preyer. When variations from a normal standard are combined with physical defects, such as paralysis, or with a bad parental or personal history, the diagnosis is easier.

#### CLINICAL DESCRIPTIVE TYPES.

*Hydrocephalic Idiocy.* Includes the cases in which the mental feebleness is due to pressure on the cortex brought about by over-distention of the ventricular cavities of the brain with fluid. It may also complicate tumor cysts or may be a sequel to meningitis; it often exists as an independent condition. It has been assumed that it owes its origin to closure of the foramen of magendie so that communication of the ventricles with the sub arachnoid space is shut off.

*Microcephalic Idiocy.* Both skull and brain are uniformly diminished in size, without paralysis or other evidence of focal lesion to account for it.

As a cause of this condition premature closure of the sutures is advanced. The question is important in its surgical aspect the fact that microcephalia can occur and the sutures remain open; the absence of such valuable evidence, that, in cases of closure, is an evidence of degeneration which affects the development of the brain as well as that of the skull, have all led to the conviction that early closure is not sufficient to explain the condition.

*Paralytic Idiocy.* Are the cases in which gross cerebral lesions occurring in infancy and early childhood cause paralysis of the limbs. As has already been said, focal lesions during development are prone to affect the brain in its entirety.

There are three forms: *Hemiplegic, Diplegic, Paraplegic.*

The result from hemorrhage, thrombosis, and less frequently embolism, intracranial inflammation and new growth. The hemiplegic type the more frequent.

Epileptic idiocy—about 20% of epileptics undergo mental arrest or enfeeblement. Epilepsy stands in a causal way to feeble-mindedness, in two chief ways:

1. Both the convulsive phenomena and the stoppage of the intellectual growth may result from a common organic cause, such as, cerebral palsies, tumors, cysts, meningitis sequelaë, hydrocephalus. In such case, the epilepsy may not occur for months or years after the mental trouble has developed.
2. The epilepsy developed first, so that it seems that the attacks themselves brought about the feeble-mindedness. Idiopathic epilepsy is also capable of checking intellectual progress; the gross cause is not known.

*Traumatic Idiocy.* One can only be guided by history of trauma from one of the members of the family. Clinically, they show no distinguishing features.

*Sensorial Idiocy.* This class includes mental defects observed in children who have lost one or more of the special senses, sight or hearing with its attendant mutism.

*Amaurotic Family Idiocy.* Rare condition. Common to Hebrew children. Occurs between second and eighth month of life. There is degeneration of the whole cerebro-spinal nervous system with impairment of sight and mental defects.

*Glandular Inadequacy.* Caused by inadequate secretions of the various glands, thyroid, pituitary and gonads.

*Cretinism.* Is endemic in Europe. Sporadic in this country, is due to a defect in the secretions of the thyroid gland. There are three grades of Cretins depending upon the degree of hypothyroidism. The lowest grade in which the defect is the greatest, called Cretin; the middle grade, called the semi-cretin; the third the highest grades, the cretinoids.



*Mongolism* or *Kalmuc* type of defectiveness, so called because of the resemblance of the patient to the Mongolian race. In the true sense it is congenital not hereditary. This condition is usually the result of worn out reproductive capacity. Corresponding to the presumption the Mongol is generally the last child born in the family, and not unfrequently comes from good stock.

Mongolism is at times hard to differentiate from cretinism. The tongue is large; papillæ hypertrophied; marked irregular transverse fissure. The condition of the tongue is characteristic of type and is not found in any other variety.

*Mentally Backward Child.* In addition to the various classes of defective mental development which have been described, we have the backward children, who are not idiots and yet cannot be called feeble-minded, yet they are backward. In many cases, the principal defect seems to be a failure of attention, without there being any demonstrable physical cause. Some of these cases are due to temporary conditions and are susceptible of removal with the cure of the patient. Among the temporary conditions are visual disturbances; errors in refraction; disturbance in hearing; general disturbances of nutrition; and possible disturbance of naso-pharynx.

*Prognosis.* In a large number of congenital or early developed cases death occurs in the first few months or years of life. The patients are particularly subjected to such diseases as diarrhoea and pneumonia. From all points of view the defective and feeble-minded are poorly equipped for the struggle for existence and die prematurely. Those who survive infancy die before twenty, few live over forty. The prognosis as regards the intellectual condition is solely a question of improvement.

#### TREATMENT.

##### Medical, Surgical and Pedagogical.

*Medical Treatment.* Is not different from the medical treatment of children generally, that is as to diet, clothing and general hygiene.

*Surgical Treatment.* Is rarely if ever justifiable. The tapping of the lateral ventricles in hydrocephalus and trephining in microcephalus, on the theory of premature ossification is being tried from time to time but there is considerable doubt as to the amount of good derived.

*Pedagogical Treatment.* Is to increase the tone of senses; to teach the co-ordinate use of muscles, to install good habits; to eliminate bad habits; teach the use of language, endeavor to teach the ideas of forms, of numbers, of length, weight, surface, of solids and finally to apply these results to higher education. Walking is taught by increasing the strength of the legs by massage and passive movement, and by mechanical devices. The teaching of cleanliness of person by regularity of habits. Speech is taught, by oral method and constant regular exercise. The manual exercise and industrial training naturally follows after the simpler things have been learned.

#### CONCLUSION.

##### Mendelism.

1. If two normal parents whose families are free from mental defects have children, all children will be normal. Their children incapable of transmitting defects to their offsprings.

2. If a normal person whose family is free marries a mentally defective person, although all the children will be normal a certain number will be carriers of the taint. If the second parent is actually defective half of the children will carry it, but on the other hand, if the second parent merely carries it, but does not show it, only one in every four of the children will carry the defect in the germ cell.

3. If both parents are normal and yet both carry the taint, then one in every four of the children will be defective and in addition two out of every three of the normal children will carry the defect, while one will be entirely free.

4. If both parents are defective, all the children will be defective.

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### GENERAL TREATMENT OF NERVOUS DISORDERS.\*

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Church gives interesting data concerning the attitude of the unthinking public towards the insane. He observes that it is not long since the insane were believed to be possessd of devils and

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accursed. On the other hand it was supposed that the souls of the insane had been removed early by God as a special mark of favor, and they were therefore blessed. Medieval treatment was founded upon the curious pathology just described. One portion of the world ducked, whipped, tortured, chained in dungeons and occasionally burned the insane. After a time many of the therapeutic measures employed by the Europeans of the middle ages were abandoned as unsatisfactory. But society had to be protected, so that the insane were fettered in the cells of jails and fortresses and solitary towers, until a realizing sense of the inhumanity of such treatment struck a responsive chord somewhere in the breast of a Tuke, a Connolly, a Pinel, a Rush and other immortals before and after them. Insanity gradually came to be looked upon as a disease and not a penal offense and instead of prisons, special buildings were set apart for the custody of the insane. The great object of the asylums was to afford protection to society from lunatics. A hundred years ago, however, the asylum was still a species of jail, for its evolution had not yet proceeded far. Indeed, it is scarcely over eighty years since Norris, a patient in Bedlam Hospital, in the great Christian city of London, was kept twelve years in a cell, with an iron collar riveted around his neck and iron bands and rings around his wrists, arms and ankles, the neck being fastened to the wall and the leg to a rude box of filthy straw.

Today, the well conducted hospital for the insane is happily different than years ago. The patient in many of these institutions is now attended by specially trained nurses and treatment is carried out under the supervision of a trained asylum physician, under ideal surroundings.

The treatment of mental disorders is a very broad subject and in the time allotted for this paper it will be impossible to cover the ground and do justice to it. However, an attempt will be made to bring to your attention the most salient points in the therapy and management of the more common forms of mental disorders and the means at our disposal in accomplishing this.

As the term "Mental Disorders" may be interpreted to include any disease presenting mental symptoms, our remarks will be limited to those states seen in the course of the psychoses. Such conditions resulting from mental inferiority, such as idiocy, etc., will not be considered.

Obviously enough, our first aim before undertaking the treat-

ment of any case, should be to make a thorough examination of the patient and to establish, as nearly as possible, a diagnosis. In many ordinary physical illnesses, a diagnosis may be possible at a first visit, but in most mental disorders this is not feasible. It is often necessary to keep the patient under observation for days, weeks and sometimes months before a proper diagnosis can be made and, furthermore, this observation must frequently be made with the help of trained attendants in proper institutions. During the time the patient is under attention, he requires to be taken care of and the particular mental state present should be our guide in the management of the case. The mental states will vary according to the particular psychoses of which they form a part, but in the main will consist of depression, excitation, stupor and dementia.

This brings us to consider whether it should be necessary to keep the patient at home or in an institution. Many contend that a great many cases can be treated at home and others maintain that few cases can be properly and safely taken care of in such a way. Obviously, all cases presenting homicidal and suicidal tendencies, as well as those under great excitement, with noisiness, persistent refusal of food and with dirty habits, should at once be under institutional supervision. It is only in the homes of the very rich, where a part of the house can be turned over for the occupancy of the patient and his attendants, that cases of even severe mental excitation can be treated extramurally. Few can afford the expense attendant upon such a course and we are therefore confronted with the necessity of sending most of these cases to an institution, where the primary requisites for the safeguarding of the patient from injury to himself and others, are adequate.

Regarding treatment, it would be well to study what means we have at our disposal to influence the course of mental disorders or to mitigate the symptoms thereof. Primarily, our attention should be given, as in other illness, to the condition of the bowels and as usually costiveness is a rule, drastic purgatives are always in order. Then we may have recourse to the following means, as circumstances demand: Rest, both physical and mental, in bed, if possible, accompanied by proper feeding, forced when necessary; to obtain this rest, it is necessary to have recourse to other means, such as hydrotherapy, medication, restraint, either mechanical or chemical. Complete mental and physical rest is important, not only in the depressed, but in the excited mental states. Rest in



bed should be insisted upon in all acute cases, particularly in melancholia and, if possible, in mania. Bed treatment in such cases has been in use since 1865. It is true that in carrying out such a treatment there are many difficulties to be overcome, but with a little persistence on the part of the attendants, it is usually feasible. It should never be thought of to send a patient laboring under acute mental depression or melancholia to seek distraction by travel or the like. Such patients should be kept in bed until the depression has subsided or his condition has materially improved.

The nourishment of these patients should be maintained at least to the point of keeping up their normal weight. The depressed and melancholic will frequently refuse food and it may become necessary to have recourse to forced feeding. The refusal of food is also a frequent reason for these patients to be taken care of in institutions. Tube feeding is a difficult procedure and demands special care by trained attendants, as it may have to be kept up for a long time. The excited patient usually eats ravenously and well for him, for the physical stress under which he is laboring may cause exhaustion, which may prove fatal. Overfeeding here is of great importance. Articles of diet should be varied and consist of very nutritious food, three or four quarts of milk and cream, with eggs in great number forming the greater part of the diet. Feed the patient often, with plenty of wholesome food. Overfeeding at night may help to induce sleep.

In the properly equipped institutions of today will be found means for the use of hydrotherapy, which has become one of the most valuable and indispensable means of treatment of mental disorders. It may be used as hot baths local or general, as a full bath, hot or cold; also as wet pack, hot or cold, and sitz bath. The stimulating effect of a needle bath may also be given. The effect of these measures are eliminating, stimulating and sedative. When treating patients in a toxic state, the hot air, inducing sweat, will prove of great benefit. The wet pack is a procedure to be employed only with the most extreme caution, since it is exhausting. It is used principally to subdue excitements of such violent character as is likely to prove dangerous, but should not be resorted to unless the patient is in fairly good physical condition. It should not be given for more than twenty minutes. In milder conditions of

excitement, the sedative effect of a warm bath will prove of great value. In later years prolonged bath has been used as a means of quieting excited patients. These are continuous with temperature of 95 to 97 degrees. They may be kept up for a long time, sometimes for hours and even days. Provision should be made for continuous inlet and outlet for the water. The patient receives nourishment while in the bath. It is claimed that even the very excited cases, who at first refuse to even enter the tub, when they are finally induced to do so, show a liking for these prolonged immersions. These prolonged baths have such a sedative effect on the patient that frequently it becomes unnecessary to use physical restraint.

Most frequently, however, before recourse is had to hydrotherapy, it may become necessary to make use of medication not only for the purpose of calming excited patients, but to relieve the insomnia. To induce sleep, recourse may be had to paraldehyde, in one or two teaspoonful doses. Its effect is usually prompt, but its taste is somewhat objectionable. Sulphonal may be used in twenty to thirty grain doses. Though it is slow in action and may not cause sleep the first night, its repeated use will accomplish the purpose and quiet the patient for the greater part of the next day. It has very little taste and may be given in the food. Trional acts more quickly, but according to some observers, may cause the degeneration of neurones and should be used with caution. Another drug that may be used is veronal in five, fifteen and twenty grain doses. The newer drugs, such as dial-“ciba” and veronal sodium (medinal), also luminal sodium, may be used in milder cases. The bromides are slow to act and may be given to quiet the patient rather than to induce sleep. Hyoscin hydrobromate, 1/100 to 1/50, is a very valuable drug and may be given to very excited patients, sometimes in conjunction with morphine. Opium and its alkaloids should be avoided, if possible. Jones, of Minneapolis (*Journal-Lancet*, August 15, 1919), says that opium still holds its place as a safe and comfortable agent in the depressed states. He says that it is necessary to give enough opium to produce a physiological effect and from one to four grains three times a day is not an excessive dose. For some reason it does not interfere with or dry up the secretions of the body, neither does it cause the constipation that is so commonly accredited to it, if the channels are kept well watered and oiled.

We have mentioned the drugs that are commonly used for sedative or hypnotic purposes, but it frequently becomes necessary to give drugs for stimulating and general tonic purposes. We then have recourse to strychnine, iron, cod liver oil, etc.

With regard to psychotherapy in mental disorders, it is here appropriate to quote from White (Outlines), page 35:

“Remember that in mental disorders that are due to mental causes something may be expected from a direct appeal to the mental condition as a result of which the symptoms developed. The human soul is filled with desires, vague longings and in its efforts to bring about its state of contentment, of satisfaction, often becomes hopelessly involved in attempts at adjustments to conditions which are quite impossible. The failure is felt keenly, but the true cause is unknown. It is for the physician, after following the difficulties and intricacies, to take the patient frankly into his confidence and by pointing out the exact mechanism of his distress, by putting his finger accurately on the difficulty, so give the patient his opportunity to meet the problem in an efficient way.”

In conclusion, I desire to lay stress that while this paper calls attention to but a few points relative to the general treatment of mental disorders, it should not be forgotten that disorders of other organs may be found in those suffering from mental diseases, and these must be given due attention.

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## MEDICO-LEGAL ASPECT OF INSANITY TO MEDICINE.\*

By DR. J. A. O'HARA.

A great number of unfortunate individuals are instinctively criminals, the results of their mental illness; but how many, and what are the proportions, is a hard problem to answer intelligently. To this type are closely allied the sneak and petty thief, drug addicts, and different forms of street beggars (and some of the unsuccessful bread earners), all of whom can be safely written, within the shadows of these remarks.

That they are the end, or by-products of an inherited mental impairment, environment and education, and, therefore, they are

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\* Read before the Orleans Parish Medical Society, October 25, 1920. Symposium on Mental Disorders.

unable to correct their mental attitudes at an age early enough to rescue or protect them; and while they are wandering along the highway of life, when the fork of the road is met, they naturally follow the lines of least resistance and they turn off into an atmosphere of degeneracy that embraces all that appertains to vice and crime.

Society not only demands that they be protected against the burglar, who would rob and also kill, but also against the Dementia-Praecox, with his many forms of mental unrest, the ever dangerous paranoiac, who, following some sudden mental shock, becomes immediately converted into the most dangerous of all insane patients, one who would kill or destroy, and while under systematized delusions of persecution, he becomes a violent insane, with suicidal and homicidal tendencies, against the result of the epidemic in his irresponsible state, or the imbecile who may murder a helpless infant, merely to appease or gratify his physical and mental desires.

These few forms of insanity do not by any means cover the wide field so closely allied to crime, but collectively they do show that some wonderful strides have been accomplished in scientific hospitals, psychopathic clinics, houses of detention and schools of correction, etc. that are developing rapidly in the civilized world, which will assist in the correction, to a great extent, of the criminal insane.

The epileptic and feeble-minded, whom we recognize as owing their origin largely to the defect of social organism, and since we are greatly responsible for these unfortunate delinquents and dependent classes they must share our humanity, our protection, our support and our pity.

Throughout this wonderful, resourceful and wealthy country of ours hundreds of insane are being sent into prison, to be punished for acts that are nothing but the results of purely systematic expressions of an unrecognized mental illness from which they suffer.

And *sane* and *dangerous* criminals are being *sent* to insane asylums on account of their *skillful* malingering ability at time of the trial.

And insane criminals are being *liberated* from insane asylums only to go back to society for another outburst of insanity, because while under proper confinement and environment, and while under



no mental taxation, they apparently return to their normal equilibrium. I have been outspoken in belief that an insane murderer or rapist, no matter to what type he belongs is more dangerous to society than a *sane* criminal of any type or character.

Most of our criminal courts are interested, on account of their legal training, in the infliction of penalties for crime, by sending men to prison to reform and make them repent, than they are in the study of the fundamental cause of crime, which brings the defendant back into court along a narrow, crooked but well-beaten path.

But the dawn of the day is now clearing the foggy atmosphere, and our legal friends are awakening to the undisputed facts, that for years they have been dealing justice out to many unfortunates from the short arm of the scale of justice; instead of trying to reform criminals by removing the cause, they have been trying to mould the effect so as to temper justice. This points strongly to dealing with individuals early in life, where in the children's court, which is the outpost in the psychiatric study of delinquency, when, even if it were impossible to intervene in time to prevent the first departure of delinquency, there is yet time to interfere with their reactions to become habitual, and devise some method for their mental reorganization. For instance, take a normal mind; let it be bombarded by passion, emotion, apprehension or depression, etc. for a continued or limited time, there will follow vasomotor and trophic disturbances with an anabolic suspension, and a resulting accumulation of catabolic products, with a final here and there, in more or less circumscribed area, then will develop rumimentary diseases. What the brain sees and hears is not the only trauma, but also by what it suffers of fears; in short it suffers from the psychical contents of emotion and passion, which is followed by such well defined diseases as psychasthenia, neurasthenia, hysteria, amnesia, or more permanent forms of insanity, depending only on the psychoneuropathy of the individual.

With these undisputed facts before us, we can easily understand why a continued emotion or depression, resulting from a combination of prolonged anxiety, anticipation, fixed attention, insomnia and grief, all of which are the advance agents of depression, which in time, is the final to the loss of memory and chronic exhaustion and psychosis. With this and other complex symptoms, from which

follows the fact that an absolute mental disarrangement can, and will result from certain causes of shock, acting like a trauma, causing congestion, etc. of the brain contents.

Oppenheim says psychopathic shock will cause a dissolution of the nervous elements. Ransi states that in the conspicuousness, rapidity and gravity of its psychopathic effects, "fright" is closely comparable to trauma, and is capable of causing shock, and shock has been known to cause and produce amnesia, hysteria, epilepsy, neurasthenia, psychasthenia, and amentia. Such being the facts, we turn our memories back to what Dr. Somnee, in his writing, under the caption, "Contributions to the study of the Insane," says, that 75 per cent of the cases of criminals are predisposed to insanity, the results of either insanity, eccentricities of manner, irritability of character, brutal impulses, drunkenness, lues, brain concussions, etc. It is an easy matter to conclude that such predisposed persons can easily have a mental twist under any adverse circumstances, for instance, the crime itself—the excitement incident to the act, the publicity, the remorse, the regret, the worry of family and relation, the sad outlook of the future, and the hopeless situation, especially in the face of violent death or a long sentence, all of these crowding fast and thick upon the already tottering brain, add these to the sudden change of the mode of life, curtailment of freedom, forced subjection to an unaccustomed and severe discipline, and lack of exercise, and consciousness must become more cloudy, and irresistibility follows soon in its wake, and we have the dawning of illusions, hallucinations delusions and fixed ideas, emotion, psycho-motor disturbances, with a final central trauma that may end in a terminal dementia, depending entirely upon the predisposition of constitutional make-up of the individual.

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## METHODS OF EXAMINATION. \*

By DR. LOUIS V. LOPEZ.

In psychiatry it is absolutely essential that a complete examination of the patient be made. This should not only include a record of the symptoms which the patient may reveal when coming to

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\* Read before the Orleans Parish Medical Society, October 25, 1920. Symposium on Mental Disorders.

the psychiatrist for treatment, but must also include the most detailed obtainable history of the patient's family, his past history, his habits and mode of living, also any information from a relative or personal friend that might throw light on the case.

The modern trend in psychiatry is to look upon any individual suffering with a psychosis as being "a biological unit reacting to certain inimical conditions" instead of the psychosis being a something that comes from without, attacking and seizing on the patient like a bacteriological or infectious disease, for instance.

To fully understand a given case, it follows, therefore, that it is of utmost importance to have known the individual before he became afflicted, or else obtain a graphic description from an informant who knew him, so that the symptoms which he presents when psychotic can be appreciated in their true light.

The outline of examination which I will now present is that of the mental status of the patient. It is taken for granted that all of us here are familiar with the various methods of physical examination. However, it does not mean that an individual who has a psychosis should not have a complete physical examination. On the contrary, all psychiatric cases should be thoroughly investigated physically and from the neurological standpoint as well.

The examination of a mental case should be a record of facts in the patient's way of reacting to various tests rather than vague statements by the examiner, such as: "Patient lacks judgment" he is "disoriented" or "Memory is defective."

These are conclusions or opinions and are of no value except, perhaps, to the examiner who reaches these conclusions.

It would be much better instead of saying "His memory is defective" to say "The patient in the course of the examination is given an address—718 Canal Street. After five minutes he is asked to recall it. He gives the name of the street but cannot recall the number at all."

Of such statements should the record of an examination be compared as it consists of a definite fact—not a mere conclusion with no basis of facts.

The mental examination may be made after the physical and neurological has been completed or first. There is no fixed rule. It depends on the individual case. The examiner should use his judgment.

We may ascertain the mental status in a given case under the following headings:

I. General Behavior. II. Stream of Talk. III. Mental attitude and Mood. IV. Memory for Remote Events. V. Memory for Recent Events. VI. Retention. VII. Orientation. VIII. Habits. IX. General Information and Education (Including Calculation—Forward and Backward, Association). X. Judgment and Insight. (Modified after Van Wart's Outline).

I. By "General Behavior" we really mean the spontaneous behavior of the patient. So here we should place a description of what we observe in the behavior of the patient while he is not aware of the fact that he is under observation. Also facts concerning his conduct from the nurses or relatives in contact with him. This description should be in plain English terms and should be done so as not to attract the patient's attention, because we want to get the spontaneous behavior.

We should note his general appearance. Does he look sad, fearful, gay, hostile, suspicious, visionary, expressionless, apathetic, intent, arrogant, sleepy, cyanotic? The care of his person and clothes. The character of his movements. Is he quiet, restless, anxious, agitated? Are there stereotyped movements? Does he walk slowly or quickly? We should also observe in the facial expression and his general appearance if there is any evidence of mental deterioration.

II. Under "Stream of Talk" we should record the answers to the following questions: What is your name in full? Where do you live? How old are you? What is your religion? Are you married or single? What is your occupation? What is it brings you here or why do you consult a physician?

We should record here some samples of the patient's utterances, especially if it is irrelevant, also ability to repeat test phrases. We should also note if patient is loquacious or laconic and if he loses goal ideas and is circumstantial.

III. Mental Attitude and Mood: Do you feel all right, or depressed, or excited or indifferent? Are you always this way? If not, how are you at other times? How were you 6 months ago? When did this feeling begin? What was the cause of it? Did it come on suddenly? Are you sad or afraid? (a) Have you had any particular experiences? (b) Is anything being done to you



or has anything been done to you to make you sad or afraid? (c) What is it you fear? (d) Do you think you are being watched, or talked about? (e) Have you any enemies?

Here we should obtain an account of the patient's mood—whether depressed, happy, anxious, perplexed; the presence or absence of hallucinations or delusions and the patient's explanation of his own case.

When the patient is in a stuporous state or delirious, it is sufficient to record a sample of the patient's talk and a description of his activity and his behavior.

#### IV. Memory for Remote Events:

Here it is well to incorporate the family history, his personal history including his illness, injuries, operations or any special events which might throw light on the case. It is important to check his answers, whenever possible by some relative or friend.

#### V. Memory for Recent Events:

There are many tests that can be used here. A very practical one is to ask the patient to remember the meals he had on the previous day. The date of his last visit or any other means that may suggest itself to the examiner to determine if the patient remembers experiences and events which have occurred within a week of the examination.

#### VI. Retention:

There are many tests that can be utilized for this purpose. A very practical and satisfactory one is to give the patient the name of a city, a flower and a color and see if patient remembers this in 3—5 minutes. Another test is the repetition of 4 or 5 to 6 units—viz:—37485 or else an address—such as 814 Carondelet. A telephone number. When a defect in retention is suspected there are some more complicated tests that can be used.

#### VII. Orientation:

Time, place, people, the date of the month, day of the week, the place he is in and the people around him. All of this should be recorded under this caption.

#### VIII. Habits:

Under this head we should investigate patient's use of alcohol, tobacco, drugs, sex habits, venereal infection and habits of every day life.

#### IX. General Information and Education:

Here we should ascertain how long he went to school. Grade attained. Discuss current events. Capital of the state. Local news. Calculation tests should be incorporated here. Subtraction: 7 from 100. Few multiplications: Supposing had 50 cents spent 12 cents for bread; 7 cents for stamps and 10 for candy, how much change? Count 1 to 20—20 to 1 recording time. Forward and backward association—months, days of the week: 752186, 35729, 6418. The power of attention and content of thought can be ascertained by having the patient read aloud one or two of the following stories and afterwards asked to give the point of the story in his own words.

#### A COWBOY STORY.

A cowboy from Arizona went to San Francisco with his dog, which he left at a dealer's while he purchased a new suit of clothes. Dressed finely, he went to the dog, whistled to him, called him by name and patted him. But the dog would have nothing to do with him in his new hat and coat but gave a mournful howl. Coaxing was of no effect, so the cowboy went away and donned his old garments, whereupon the dog immediately showed his wild joy on seeing his master as he thought he ought to be.

#### GILDED BOY STORY.

It is related that at the coronation of one of the popes about 300 years ago a little boy was chosen to act the part of an angel, and in order that his appearance might be as gorgeous as possible, he was covered from head to foot with a coating of gold foil. He was soon taken sick and although every known means was employed for his recovery except the removal of his fatal golden covering, he died in a few hours.

The ability to repeat one of these stories shows in a practical manner the power of attention, amount of interest, memory, the tending to elaborate forgotten details to elaborate the story with invented additions and their character, to lay stress upon the emotional data, the ability or failure to see the point.

#### X. Judgment and Insight:

Ethical questions: If you saw a man drop a \$10 bill, what would you do? Why is it wrong to steal? If you were going away and missed your train, what would you do? Any question which

can show errors of judgment can be used which may come to the mind of the examiner.

For insight we ask: Does your head feel all right? How is your mind? (If he has an insight into the condition get a detailed account of what he thinks of the whole situation). This order does not necessarily have to be carried out as presented, but if the examination of a mental case involves all the subject matter as given, we will have a very good insight into the nature of the psychosis and the individual we are to treat.

Of course, where mental deficiency exists or is suspected a Binet-Simon or one of the modifications such as Yerbes-Bridges scale can be used as an adjunct. I have purposely omitted saying anything about association tests as these come under the heading of psychanalysis and the time is too limited to discuss this.

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**DISCUSSIONS BEFORE THE ORLEANS PARISH MEDICAL SOCIETY  
OCTOBER 25th, 1920.**

**“Symposium on Mental Disorders.”**

**By Dr. Van Wart:** “Mental diseases are of great interest at present. The general practitioner sees them first. It is of great importance to recognize the early stages but it is difficult. In my opinion insanity does not occur suddenly. Usually, development is over a long period of time and symptoms are obscure. Early treatment I strongly advocate. As to the dividing line between “Sanity” and “Insanity,” (as asked by Dr. Eshleman), I would like to point out that “insanity” is a legal and not a medical term, and that the distinction is based on the ability of the patient to handle normal situations.”

**By Dr. Gallant:** In connection with Dr. Roeling’s paper on the Feeble-minded, it might be of some interest to state that some few years ago while a member of the Medical Staff of the Illinois State Hospital for Defective children, I personally investigated the histories of some 1700 Defective children, and found a distinct family history of alcoholism in approximately 40% of these children. Further investigation elicited luetic taint in approximately 18% of the same number of children examined.

I have noted that part of Dr. Cazenavette’s paper wherein he suggests maximum and forced feeding together with the use of various hypnotic drugs in the treatment of mental diseases. I do not agree with Dr. Cazenavette altogether in this regard. First, the great majority of all acute neurotic or psychopathic cases when seen in their early mani-

festations are invariably more or less toxic—luetic cases not excluded—suffering as they all do with faulty elimination. The fact that the patient has lost his mental or physical equilibrium bespeaks a logical foundation of an already disturbed metabolic process that brings about that toxicity which plays an important part in the precipitation of all mental disorders, particularly the exhaustion and toxic psychosis.

Furthermore before the actual break of the patient which brings the psychiatrist to the patient, it is more than likely that the patient has been using little if any discretion in the matter of diet by reason of the psychic complex already a disturbing factor to both family and patient. Why then force feed or drug a patient that is bound under these conditions to be already suffering from toxemia (accumulative) as well as from faulty elimination that go hand in hand adding as you will see one poison on another until for days you have a distinct masking of the patient's true condition before conservative treatment can be instituted.

I have seen patients so heavily drugged on admission to hospitals that for days we had to fight to eliminate the toxic effects of over drugging. Most general practitioners as well as others resort almost immediately to the hypodermic route in an attempt to get quick action in quieting the patient, whereas often times there are certain idiosyncrasies for a particular drug that in place of relaxing the patient set up instead a most violent mental and physical reaction. The general practitioner will make no mistake in handling in a general way as his first or temporary treatment in cases of this kind by resorting to the natural physiological methods of free and persistent catharsis—the lightest diet possible to fit the case which will insure the immediate and maximum depletion and elimination. By this humane and natural method, you afford true physiological relaxation and in turn eliminating much of the toxemia which has to do more or less with mental excitement.

Spinal fomentations are excellent in inducing rest and sleep together with other methods apart from drugs. Some of our most troublesome cases have been reduced for days and weeks to a diet almost nil and with the gradual reduction of toxemia having been effected, we have increased our diet in keeping in with the need and strength of the patient to properly assimilate until the development of the patient has been built up on lines consistent with proper physiological endurance.

In treating and handling some 300 acute neuro-psychopathic cases in the past (two years) rarely were we obliged to use morphine and I can hardly recall the use of veronal; the latter drug I consider most undesirable of any drug to use in nervous cases or otherwise.

In the larger and more highly specialized hospitals operated exclusively for the treatment of mental diseases, the use of drugs has sunk into oblivion and physical restraint in any form is now obsolete and annihilated.

**By Dr. Unsworth:** "It is very important for the general practitioner to recognize a psychosis so that the patient may have the benefit of early treatment. I would advise giving initial dose of 10 grs. of calomel and jalap. I find that Luminal and other drugs are useful, at times, to induce sleep, but I firmly disapprove of opiates. In my opinion, the predisposition is responsible for 80% of psychoses."

**By Dr. Eshleman:** "Laboratory tests in mental diseases are often unsatisfactory. I would also like to mention that Dr. Daspit's point of



view that arteriosclerosis does not cause cerebral degeneration,—is unusual.”

**By Dr. Daspit:** “Dr. Eshleman did not exactly understand my remarks. The impression I wished to convey is that while arteriosclerosis plays some part in senile disorders, we must recognize the fact that many psychotic states of this period occur quite independently of arterial degeneration.”

**By Dr. Verdier:** “If Syphilis is curable the neurological aspects of syphilis should be ultimately abolished. It is as important for the general practitioner to recognize syphilis as it is for him to recognize a psychosis.”

**By Dr. A. L. Levin:** To corroborate Dr. Van Wart’s statement that the clinical side of a case is very often more important than the laboratory side, I wish to relate a case which recently came under my observation, although the case has no bearing on the subject of neurology and psychiatry. I was called to see a middle-aged woman suffering from severe abdominal pain, inability to retain any kind of food even liquids, giving a history that for over a year she was suffering from attacks of epigastric pain and periodic vomiting, that systemic syphilis was strongly suspected in her because she gave a strongly positive Wassermann. About 15 days previous, she was given 2½ dec. of Salvarsan, since then, her condition has changed greatly for the worse. Arsenical poisoning was suspected. On examination, I found an extremely emaciated person, intensely jaundiced, marked rigidity of the upper abdomen, extremely sensitive to the touch, lower abdomen tympanitic but softer, temp. 101, rapid and thready pulse; liver enormously enlarged and hard to the touch; an endocardial lesion, no palpable glands. Her white cell count was 26000 and 91 polys; no blood in gastric contents, free HCL present. Urine for arsenic was positive. It was clear to me that I was dealing with the presence of pus either in the liver or in the gall-bladder. With difficulties, I obtained about a tablespoonful of very green muco-purulent bile by the duodenal tap method. I advised a laparotomy which was done under local anesthesia. A gangrenous gall-bladder full of pus and stones was found. Patient improving. This demonstrates that it was not the luetic condition as demonstrated by the laboratory but the clinical side of the case helped in clearing up the diagnosis.

**By Dr. Pothier:** “Laboratory tests in Wassermann reaction depend upon the presence or absence of lipoids. Experiments by Clark show that a diet of hydrocarbon for a period of sixty days often produces a positive Wassermann in previously reported ‘negative’ cases. Drinking of quantities of beer and wine have changed and did change the positive Wassermann to negative.”

**By Dr. Otis:**—Suggestion of advancement along intelligent lines in mental hygiene, for the proper care of, not only paranoia but, all mental illness, as being most necessary at present.

**By Dr. G. F. Roelling:** “In my opinion, outside society work is also necessary for the class of patients under discussion.”

**By Dr. Lopez:** In the North, Class Clinics have just been established to find vocation for adolescence.

**By Dr. O’Hara:** “If feeble-mindedness is to be prevented or improved, I would strongly advocate the establishment of a ‘Feeble-minded

Home,' as also the establishment of a Clinic, FREE, for the study of such children, in any hamlet of the State.'

**By Dr. T. J. Dimitry:** "All that has been said in explanation of the psychoses is very interesting and instructive, but what appears very strange to me why you have devoted so much time where only twenty percent of your cases are concerned. Why have we not heard more about the eighty percent of your cases which are put under the head of faulty heredity. I feel certain that psychologists are advanced students in the laws of Mendel, Weisman and Dalton in explanation of these conditions."

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### IN MEMORIAM.

At a special meeting of the faculty of the New Orleans Polyclinic, Graduate School of Medicine of Tulane, called for the purpose, the following resolutions were passed:

Whereas, the members of the Polyclinic faculty feel keenly the death of their former colleague, Dr. Isadore Dyer, and wish to express to his bereaved family their sympathy and to record in fitting manner their sense of personal loss,

Be it resolved, that in the death of Dr. Dyer, the community has lost a public-spirited citizen, the medical profession of this city, state and nation a highly valued practitioner and honored counsellor, Tulane University a distinguished teacher and Dean of its School of Medicine, and the Post-Graduate School a cordial friend and advisor in the co-ordination of the work of the two schools of the College of Medicine.

The numerous posts of honor in varied activities of life held by Dr. Dyer with credit to himself and satisfaction to the organizations he served attest a man of great natural gifts and splendid education. As student, hospital interne, lecturer and professor, he made his mark. As dermatologist, he was well known throughout this country and he enjoyed a world-wide reputation as an authority on leprosy, of which he was an ardent student.

As lecturer on diseases of the skin in the Tulane Medical Department from 1892 to 1905 and Associate Professor from 1905 to 1908, as professor in the reorganized faculty of the School of Medicine, he won success as a teacher of undergraduate students and as Professor of Dermatology in the N. O. Polyclinic from 1894 to 1907 and as Secretary of the N. O. Polyclinic from 1895 to 1905 he endeared himself to us all.

When afterwards he left us to become Dean of the School of Medicine in the reorganized College of Medicine of Tulane University, we watched with interest his career as an organizer and felt honored by his achievements in raising the standard of medical education in spite of great financial embarrassment.

We might truly say of him what was written on the cenotaph of a distinguished poet:

“Nullum quod tetigit non ornavit.”

Resolved, that in the death of such a man, there is more than common loss and we desire, therefore to spread upon our minutes this testimony to his character and expression of our esteem:

“Nothing is here for tears, nothing to wail  
Or knock the breast; no weakness, no contempt,  
Dispraise or blame, nothing but well and fair  
And what may quiet us all in a death so noble.”

We extend, therefore, to his bereaved family our heartfelt sympathy and to the School of Medicine our sincere regret for the untimely passing of its distinguished Dean.

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In line with the above, we are pleased to publish the following communication.

Newark, N. J., October 14, 1920.

Editor N. O. Medical and Surgical Journal,  
Dear Sir:

It is with deep regret that I learn of the death of my friend, Dr. Isadore Dyer. His loss is a serious one to the cause of leprosy treatment and care. No man has rendered better services than Dr. Dyer in behalf of the scientific and effective treatment of leprosy, giving every encouragement in the curability of the disease in its early stages. What Dr. Dyer has done is a matter of record of which the American medical profession has every reason to feel proud. He was as unassuming in his ways as he was unwilling to engage in controversies, often called for to maintain his right to priority in the development of methods of leprosy treatment subsequently adopted practically throughout the world. The Louisiana Leper Home is a monument to his memory, for he was the first to

emphasize, in season and out, the urgency of effective and humane segregation. In private life he was a charming host and a sincere and loyal friend. As Dean of the medical school of Tulane University he did much to raise that institution to its present position of far reaching and powerful influence throughout the nation. His name will ever be remembered as one of the group of physicians who have made New Orleans the medical center of the South. He will live in the hearts of those who knew and loved him for his traits typical of a southern gentleman; but last not least will his memory endure in the hearts of those to whom his scientific researches and personal skill brought relief and cure for the worst affliction mankind suffers to the extent of millions of leprosy victims throughout the civilized world.

Frederick L. Hoffman.

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Whereas it is the will of an all wise Providence that our friend and professional brother, Dr. Isadore Dyer, should be called to his eternal abode, and

Whereas his loved ones have been deprived of his love, devotion, and watchful care, and

Whereas the medical youth of the Southland is deprived of his guiding hand as Dean of the Medical College, and

Whereas the medical profession of the whole country has lost one of its best men, both in the practice of his chosen profession and his contributions to medical literature,

Therefore be it resolved by the Homochitto Valley Medical Society at Natchez, Mississippi, in session assembled do hereby tender to the wife and children of Dr. Dyer their sincere sympathy in their great loss.

Be it further resolved that a copy of these resolutions be presented to his family, to the New Orleans Medical and Surgical Journal and be spread on the minutes of this society.

R. D. SESSIONS, Chairman,  
J. W. D. DICKS,  
PHILIP BECKMAN.



THE LOUISIANA LEPER HOME.

I

Amidst the stately live-oaks,  
The orange trees and palms,  
Half hid by yellow jasmine,  
A woman's singing psalms;  
Her rich melodious southern voice,  
In an undertone of pain,  
Implores her patron saint to set  
Her body free again.

II

She is called unclean and a leper,  
Deserted by all but the few  
Who know that she is pure in heart  
And never an evil knew.  
Like some shy, fluttering oriole  
In an oleander bush,  
She hides her face in sorrow,  
As her song ends in a hush.

III

Just one of a hundred victims  
Of a fate both cruel and blind,  
Left by her friends unfaithful,  
Inhumanely unkind.  
Her frail hands are disfigured  
And the sense of touch is gone,  
Her voice and sight are failing;  
Her course is almost run.

IV

A woman stands beside her  
Who for more than thirty years  
Has suffered mortal agony,  
Her eyes made blind by tears;

Not for herself, but a daughter,  
 Grown up though half a child,  
 Near to the dreadful ending,  
 In fever, talking wild.

## V

The lepers seem to form a line,  
 Like sorrow's hopeless trail;  
 Where the end is only misery,  
 Though not all the efforts fail.  
 The ministering physician,  
 With the sister's gentle aid,  
 Is rendering God's service,  
 With the debt in heaven paid.

## VI

Once more I met those whom I know  
 When first they sought relief,  
 When all was dark and dreary  
 And when hopeless was their grief.  
 But now, thank God, a few are cured,  
 No greater joy than this,  
 Returning home to wife and child  
 Or a mother's welcome kiss.

## VII

I pass the gate; though fain I would  
 Remain and render aid,  
 As I think of Father Damien,  
 And the humblest servant maid  
 Who gives her all to serve a cause,  
 Bring comfort, care and cure,  
 Blessed by the sorrow-stricken  
 Who suffer and endure.

F. L. HOFFMAN.

Mound, La., April 22, 1920.

## **BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.**

By P. T. TALBOT, M. D., Secy-Treas.

Our State Society will convene in New Orleans April 19, 20, 21, 1921. It is the wish of all that this meeting be made most attractive and that the membership roll shall be increased. The officers of the society are active in stimulating every possible thought for the betterment of the organization. The chairmen for the different sections are to be chosen promptly and those so honored are expected to be interested and desirous of working actively in providing an attractive program for the meeting. Those accepting the appointment will not be permitted to procrastinate but, to the contrary, promptness will be insisted upon. If you do not wish to work and if you are so burdened that you must defer your duties then, for the good of the organization, please do not accept.

The local society will be requested to appoint the chairman of the entertainment committee, promptly, for it is our wish to get to work early thereby make for a better organization.

Post-Graduate Course in Medicine for its members, is to be the latest innovation. Those who have the society at heart have evolved this educational feature, so that our members from isolated districts may obtain with little inconvenience assistance, from those compelled to be more active in every newer thought, and will be able to acquire a certain information in a limited time.

There are 2,100 physicians in this State and many will appreciate contact with these gentlemen and an opportunity to meet more intimately than at the scientific meeting. It is not to be forgotten that New Orleans is a medical mecca, and like all centers of learning those desirous travel great distances, here it is that the distance is not the difficulty, but will you remain long enough to acquire the knowledge offered to you? Like the oath of medicine we promise to perform our duties without fee or stipulation and that by lecture and every other mode of instruction to impart a knowledge of the art.

The difficulty which is confronting us in carrying out this plan is to know how many of these 2,100 men will be interested, will the attendance justify the energy in providing such a plan? We hope it will; then New Orleans will see the greatest gathering of

Louisiana practitioners that has occurred in the history of the society.

We will have more to say on this subject in the next issue of this JOURNAL and we will gladly receive an expression of our confreres in approval or disapproval of the plan.

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## NEWS AND COMMENT

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THE OPHTHALMOLOGICAL AND OTO-LARYNGOLOGICAL CLUB of the Orleans Parish Medical Society met at the domicile of the Society on the evening of October 26. There was a varied program and from the discussion brought out the gathering was a success and very enlightening. Plastic surgery of the lower lid in which a case was presented requesting the consensus of opinion as to "The Best Method of Replacing a Lid, which has been completely torn off." This case came in for a number of excellent suggestions and it was thought best that the lid might be reinforced if a part of the ear was used for this purpose. An interesting presentation and discussion, was a case of Monocular Trachoma." Case reports were: "What to do in spite of all treatment when the conjunctiva will not clear up preparatory to the cataract extraction." A case report of "Blood Stain of the Cornea," mistaken and operated on for dislocated lens. The next meeting will be held in the second week in December. Beside those interested in these specialties the profession is invited.

LEPER HOME READY FOR GOVERNMENT.—The Louisiana Leper Home is now ready to be turned over to the United States Government under the care of the U. S. Public Health Service. Dr. O. E. Denning will be at the head of the institution, which is fitted to care for as many as 500 patients. The Sisters of Charity of St. Vincent de Paul will continue to be in charge of the nursing and domestic arrangements for the inmates.

ALEXANDRIA TO HAVE NEW HOSPITAL.—Dr. Clarence Pierson has resigned as superintendent of the Louisiana Hospital for the Insane at Jackson. Dr. Pierson will later establish a sanatorium at Alexandria where he will care for mental and nervous disease patients. The new institution will have a capacity of from 50 to 75 beds.



HONOR TO DOCTOR EMILE ROUX.—The Director of the Pasteur Institute has been awarded the Grand Cross of the Legion of Honor. Dr. Roux, as the principal collaborator and disciple of Pasteur, has devoted a life of simplicity, modesty and research to the work of the great master. He is the discoverer of the anti-diphtheretic serum.

INCORPORATION OF MEDICAL JOURNALS.—*The Nashville Journal of Medicine and Surgery* has been incorporated in *Medical Life*, together with three other magazines, the *Mississippi Valley Medical Journal*, the *Medico-Chirurgical Bulletin* and the *American Journal of Urology and Sexology*, all of which will be continued as *Medical Life*.

PUBLIC HEALTH SERVICE TAKES OVER ARMY HOSPITALS.—Two army hospitals, one in North Carolina and the other in New York Harbor have been taken over by the U. S. Public Health Service.

RESERVE OFFICERS' TRAINING SCHOOL UNITS.—Surgeon General Ireland contemplates establishing a Reserve Officers' Training School Unit at every Class A medical school in the country. At first it was the intention of the War Department to put these units at only ten medical colleges, but it has been finally decided to include all medical schools that can enroll the required minimum of fifty students. An officer of the Medical Corps will be assigned to each school to conduct the course, which is to extend over four years, after the successful completion of which the graduates are awarded commissions in the Reserve Medical Corps.

SOCIETY FOR AMERICAN FIELD SERVICE SCHOLARSHIPS.—The Society for American Field Service Fellowships for French Universities will offer for open competition among graduates of American colleges and other suitably qualified candidates a number of fellowships, not to exceed twenty-five, for the purpose of encouraging advanced study and research in French Universities during 1921-22. Fellowships in medicine amounting to \$200 are included.

PLAGUE RESEARCH AT PENSACOLA.—The U. S. Public Health Service has established at Pensacola a research station for the study of bubonic plague. In addition to those already there a number of experts will be detailed for the work, with additional equipment provided to facilitate investigations.

MALARIA INCIDENCE GREATLY REDUCED.—It is reported by Dr.

Oscar Dowling, President of the Louisiana State Board of Health, that malaria has been reduced 50 per cent at Mound within the current year, as a result of the work done there by health officers under the direction of the State Board of Health and the International Health Board. Mosquitoes have been reduced 87 per cent. in houses in that vicinity.

SEGREGATION OF TUBERCULOSIS.—On October 1 an ordinance passed by the Covington, La., Board of Health prohibits anybody or any firm or corporation of housing for pay any consumptive within 1,500 feet of the parish court building. By this measure it is hoped to stimulate the tuberculous to live in the open rural sections rather than in the crowded part of the town and to protect visitors at the hotels from contact with the disease.

OSLER SOCIETY OF MEDICAL HISTORY.—A group of twelve physicians at the Mayo Foundation has organized the "Osler Society for the Study of Medical History." Dr. William C. McCarty, associate professor of Pathology, has been chosen president.

NURSES NEEDED BY THE PUBLIC HEALTH SERVICE.—The U. S. Public Health Service needs hundreds of nurses for its general hospital work but also and particularly for the care of former soldiers suffering from nervous and mental disorders. So great is its need for the latter class that it is probable that at present enough trained nurses are not available in the country. The Public Health Service accordingly purposes to establish a training school for nursing in neuro-psychiatric diseases in its special hospital (No. 49) on Grays Ferry Road, near Philadelphia, where nurses with general training may take a special course in this class of work. This hospital has a capacity of 240 patients and will afford exceptional opportunities for instruction in the most modern treatment. An appeal is made to nurses to come forward for this work.

THE ALL-AMERICA CONFERENCE ON VENEREAL DISEASES.—Preliminary program is out for the All-America Conference on Venereal Diseases to be held in Washington December 6 to 11 under the auspices of the U. S. Interdepartmental Social Hygiene Board and the U. S. Public Health Service, the American Red Cross together with the American Social Hygiene Association, as it is the purpose of this, the first conference, to concern itself chiefly with the control of venereal diseases. The program is so arranged

that it will be possible for any delegate to attend all meetings. Assurance has been given that no effort will be spared to make the attendance at the conference a pleasure to be remembered. All correspondence regarding hotel reservations should be addressed to the Executive Secretary, 411 18th St., N. W., Washington, D. C.

THE ALVARENGA PRIZE OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.—The next award of the Alvarenga Prize being the income for one year of the bequest of the late Senor Alvarenga and amounting to about \$250, will be made on July 14, 1921, provided that an essay deemed worthy shall have been offered. No Alvarenga Prize was awarded in 1920. For details regarding the prize those interested should address J. H. Girvin, Secretary, 19 So. 22nd St., Philadelphia.

NEW DEPARTMENT STARTED BY MEDICAL REVIEW OF REVIEWS.—Beginning in January, the *Medical Review of Reviews* of New York will inaugurate a new department for the advancement of the science of Chemo-Therapy. In order to develop the theories as set forth by the various investigators who have thus far entered this field, the cooperation of all physicians, chemists, bacteriologists and pharmacologists who are doing or contemplate doing work along these lines is invited.

CENTENNIAL OBSERVED BY THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF CINCINNATI.—On November 6 an elaborate and extensive ceremony commemorating the centennial anniversary of the College of Medicine of the University of Cincinnati took place. Among the speakers on the occasion were Sir Auckland Geddes, British Ambassador to the United States and Hon. Barton Payne, Secretary of the Interior. Others on the program included Dr. Rudolph Matas, of Tulane University and Dr. C. C. Bass, also of the Tulane Faculty.

MEDICAL GROUP PLANNED AT OHIO STATE UNIVERSITY.—A plan for the segregation of all medical buildings and hospitals in connection with the Medical Department of the Ohio State University has been approved by the trustees of the university, and architectural work on what promises to be one of the most extensive medical and hospital units in the country has been started. The group is expected to include a thoroughly modern hospital for the college of medicine, a medical research building, a dental building, and the

present homeopathic hospital facilities will be enlarged. All of the buildings will be located in a U-shaped group overlooking the athletic field at the university, on which will be erected a million dollar stadium.

**EFFECT OF CANCER UPON THE LENGTH OF LIFE.**—The loss in years of average lifetime, due to the prevalence of cancer among wage earners insured in the Metropolitan Life Insurance Company has been computed. The study covered the experience of six years, from 1911 to 1916, among the millions of policy-holders. The greatest damage is done among white females and the least among colored males. Among the latter the loss from cancer never amounts to more than a third of a year. The loss is from 2 to 2½ years for white females between 1 and 55 years of life. The maximum loss in expectation for both white females and colored females occurs about age 35. After that age, cancer exercises a diminishing influence upon the after-lifetime of females.

**THE NATIONAL ANESTHESIA RESEARCH SOCIETY.**—The first anniversary meeting of the National Anesthesia Research Society was held in October at Pittsburgh, this meeting combining the joint interests of the Interstate Anesthetists and the National Anesthesia Research Society. For the Interstate group it was the sixth annual meeting. Two first prizes were awarded and four second prizes.

**UNITED STATES CIVIL SERVICE EXAMINATIONS.**—Open competitive examinations will be held in Washington, as follows: Form 1312, receipt of applications to close December 7, for anesthetist in Freedmen's Hospital, at \$1200 a year, plus increase of \$20 a month, with board. A vacancy in the office of the Surgeon General at \$1,600 a year, plus \$20 a month, for anatomist. Vacancies in St. Elizabeth's Hospital, Washington, \$1200 a year with maintenance. The temporary increase of \$20 allowed by Congress will be given to those who are satisfactory in their services at the end of one year. Applications will be received until March 1, 1921. Three examinations will be held for position of physician in the Panama Canal Service, at salaries ranging from \$250 to \$360 and higher for special positions. Applications for these examinations will be received until March 9, 1921.

**NATIONAL TUBERCULOSIS ASSOCIATION.**—The National Tuber-



culosis Association will hold its Christmas-Seal Campaign from December 1 to 11.

THE REGULAR SEMI-ANNUAL MEETING OF FOURTH DISTRICT MEDICAL SOCIETY met at City Hall, Shreveport, on this date and was called to order by the president, Dr. Thos. P. Lloyd of Shreveport. After the invocation by Rev. Abram Brill and words of welcome by Mayor J. McW. Ford of Shreveport, District Councilor J. E. Knighton and Pres. A. A. Herold of Shreveport Medical Society, the gathering was given a treat by hearing our distinguished visitor Dr. Homer Dupuy of New Orleans, President of Louisiana State Medical Society, who extended greetings from the parent organization and then delivered an address on the subject of "Medical Parasites."

The scientific papers being then in order, Dr. Thos. Ragan read on: "An Unusual Case of Intussusception of Cecum, complicating Appendicitis," at the same time displaying specimen removed; paper discussed by Drs. Knighton, Herold and Ragan, in closing.

Dr. A. G. Heath gave an essay, entitled "Hypertrophied Anal Papillæ;" discussed by Drs. Knighton, Ragan, Crain, Hunter and Heath, in closing.

A paper on "Enuresis" by Dr. M. S. Picard, was discussed by Drs. Gorton, Crain, Bodenheimer, Herold, Dupuy and Picard.

Dr. W. B. Allums of Ringgold read on "Uses and Abuses of Pituitrin;" discussed by Drs. Irion, Jarrell and Allums.

Upon request of the President, Dr. Dupuy made a few remarks for the benefit of the late arrivals. Miss Clara Bubenzer, Public Health Nurse, was then given the floor; she told of her work and asked for cooperation of the doctors. The attendance at afternoon session totaled 37.

The evening session was held at the Schumpert Memorial Sanitarium and was in conjunction with Shreveport Medical Society. The secretary read a letter from Dr. Oscar Dowling, expressing regret at his absence. Dr. Knighton read the report of memorial committee, in which the deaths of Drs. Blanchard, Callaway and Hunt were deplored. Dr. C. H. Irion of Benton reported several cases of abortion; this report was discussed by Drs. Willis, Garrett, Crain, Ragan, Eaddy, Kimbell, Hunter, Sanderson and Irion. Adjournment was then taken to the dining room, where a bountiful supper was served; after this, an unanimous vote of thanks was

tendered to the Sisters. Paper No. 1 on the evening program, "Facts, Fads and Fancies concerning High Blood Pressure" was read by Dr. R. H. Blackman; discussed by Drs. Nelson, Knighton, Tucker, Kimbell, Ragan, Herold and essayist in closing. No. 2 was on "Hematuria" by Dr. I. B. Rougon; it was discussed by Dr. Hunter. Dr. S. C. Barrow exhibited some interesting X-ray plates on gastro-intestinal tract, including appendices. Dr. C. P. Rutledge showed some unusual bone cases and one of an enormous cardiac area, due to pericardial effusion.

Election of officers for ensuing year resulted as follows: President, H. W. Jarrell of Mansfield; 1st vice-pres., C. M. Tucker of Haughton; 2d vice-pres., I. B. Rougon of Shreveport; sec.-treas., W. S. Kerlin of Shreveport. The meeting then adjourned to meet again in Shreveport in the spring of 1921. The entire total attendance was 69.

THE LOYOLA UNIVERSITY series of lectures which were given last year at its Post-Graduate School domicile will be resumed this session beginning Wednesday Dec. 1st, and will be delivered on the first and third Wednesday of each month, at 8 p. m., in the Assembly Room.

A partial schedule is as follows: December 1st: Prof. Jos. A. Danna, on Thoracic Surgery. December 15th: Prof. J. M. Batchelor, on Bone Surgery. January 5th: Prof. T. J. Dimitry, on the Laws of Heredity in Explanation of Ophthalmic Deficiencies. January 10th: Prof. A. L. Levin, on the Treatment of Amebic Dysentery. The medical Profession, Graduate and Pupil Nurses and the Medical Student Body are invited to attend.

THE SOUTHERN MEDICAL ASSOCIATION at its closing session on November 18, in Louisville, elected Dr. J. L. Crook, of Jackson, Tenn., as president; Dr. E. B. Block, of Atlanta, first vice-president; Dr. G. A. Hendon, of Louisville, second vice-president; Dr. Seale Harris, of Birmingham, was re-elected secretary. Hot Springs, Arkansas was selected for the next annual meeting.

THE ANNUAL MEETING OF THE MEDICAL AND SURGICAL STAFF OF THE CHARITY HOSPITAL was held October 26, 1920, in the Miles Amphitheatre. Dr. F. W. Parham, President of the Staff, submitted his report for the year. As retiring president a rising vote of thanks was tendered him for his splendid and indefatigable effort

in the organization of the Society of the Medical and Surgical Staff of the Hospital. As it traces the activities of the Society from its inception, the President's report is of great interest. In this report the President laid stress on the monthly report of services; there seems to be some misunderstanding as to the disposition of these reports which should be submitted to the Superintendent and not to the secretary of the Staff nor to the various sections unless so requested by these sections. In the case of the surgical section, duplicate monthly reports are to be revised by a special committee of three for the purpose of drawing up a program for discussion for the monthly meeting.

Among other points stressed by the President was the importance of Division meetings. Some Divisions have not reported, and a few have not even met for the purpose of organization.

The General Body resolved to recommend to the Superintendent and the Board of Administrators that a separate division of Neurology and Psychiatry be created.

The result of the annual election was as follows: President, Dr. E. D. Fenner; Vice-President, Dr. T. J. Dimitry; Secretary-Treasurer, Dr. Muir Bradburn; Conference Committee, Drs. S. M. D. Clark, Alvin Love, Randolph Lyons.

PERSONALS.—Dr. C. Cross, a former staff member of the International Health Board and recently director of Rural Sanitation in Mississippi, has been forced through ill health to give up a work to which he had hoped to dedicate his life. The splendid county health organization of Lee County, Mississippi and the improved sanitation of several other rural areas of Mississippi are proof enough of Dr. Cross's faithful work in that state.

Dr. A. G. Heath was unanimously elected parish health officer of Caddo, succeeding Dr. Frank Walke.

REMOVALS.—Dr. M. Newhauser, from Alexandria to Shreveport.  
Dr. Lambert G. Poree, from Los Angeles, California to 1020 N. Roman St., New Orleans, La.

Dr. C. A. Wyatt, from Haslam to Marshall, Texas.

Dr. Louis J. Stumpf to Maison Blanche Annex (Audubon Bldg.)

DIED.—Dr. Ben. S. Story, of Happy Jack, La., on November 15, aged 65 years.

## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for October, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	2	1	3
Intermittent Fever (Malarial Cachexia)	1		1
Smallpox		2	2
Measles	1		1
Scarlet Fever			
Whooping Cough	2	1	3
Diphtheria and Croup			
Influenza			
Cholera Nostras			
Pyemia and Septicemia	1	1	2
Tuberculosis	27	27	54
Cancer	17	5	22
Rheumatism and Gout	1		1
Diabetes	4	1	5
Alcoholism			
Encephalitis and Meningitis	1		1
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	17	13	30
Paralysis	2		2
Convulsions of Infancy			
Other Diseases of Infancy	14	16	30
Tetanus	1	1	2
Other Nervous Diseases	5		5
Heart Diseases	45	35	80
Bronchitis		1	1
Pneumonia and Broncho-Pneumonia	16	21	37
Other Respiratory Diseases	2		2
Ulcer of Stomach	3	1	4
Other Diseases of the Stomach		3	3
Diarrhea, Dysentery and Enteritis	7	7	14
Hernia, Intestinal Obstruction	6	1	7
Cirrhosis of Liver	5	3	8
Other Diseases of the Liver		1	1
Simple Peritonitis			
Appendicitis	9		9
Bright's Disease	22	13	35
Other Genito-Urinary Diseases	7	8	15
Puerperal Diseases	3	2	5
Senile Debility	2	2	4
Suicide	4		4
Injuries	27	18	45
All Other Causes	26	7	33
<b>TOTAL</b>	<b>281</b>	<b>191</b>	<b>472</b>

Still-born Children—White, 24; colored, 31; total, 55.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 100 per annum for Month—White, 11.63; colored, 20.73; total, 14.16. Non-residents excluded, 12.42.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure ..... 30.09  
 Mean temperature ..... 71  
 Total precipitation ..... 3.59 inches  
 Prevailing direction of wind, southeast.



# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

EDITOR: CHAS. CHASSAIGNAC, M. D.

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## THE NEW YEAR.

We wish all of our patrons—advertisers, readers, subscribers—a Happy New Year. While it must be admitted that present indications do not point to a brilliant beginning we believe that, as soon as the necessary adjustment of conditions has taken place and a relative stabilization has followed, things will improve and the rest of the year may be reasonably prosperous.

At any rate we can all get a good deal out of 1921 if we go about it in the right way; if our aims are lofty and we strive earnestly, we can accomplish much; if we accept the results philosophically we can obtain at least a fair modicum of happiness and that we sincerely hope will be true in the case of all our friends.

Our endeavor during the year will be to make the JOURNAL more interesting and more useful to our clients and, with that end in view, we are planning new features which we propose to inaugurate from time to time. We invite suggestions and request the co-operation of our readers in order that this year may prove to be one of progress and profit both for them and for us.

**PNEUMONIA.**

The period of the year is approaching during which the menace of this dread disease is greatest in this section of the country. It is timely, therefore, to remind the members of the profession that theirs is the duty to do the utmost towards prevention by instructing their clientele as to the most important facts regarding the cause and spread of pneumonia.

The malady is an acute infection produced by a specific organism which may be transmitted by means of the hands or eating utensils through the mouth and, through the respiration, by means of coughing, sneezing and spitting. It is not due to cold weather of itself or to "catching cold", although chilling of the surface and continued exposure may increase the tendency to the disease owing to the lowered resistance induced. Hence people should be taught to avoid getting wet or chilled; to be sufficiently clad, yet to have plenty of fresh air; to avoid overcrowding and overheating; to cultivate cleanliness of person and of the things they handle; to avoid exposure to infection, hence to practice the isolation of patients sick with disease. If disease should appear, the importance of seeking early treatment and securing good nursing should be impressed upon the public and the physician should be prepared to administer the most scientific and approved treatment, avoiding fads and freakish methods.

While no sensationalism should be indulged in and the people should not be frightened, it is well to make them understand that pneumonia is one of the most serious diseases with which we have to contend and that it causes a large percentage of the deaths occurring here in the late winter and early spring.

By means of a conservative and rational campaign of education, somewhat on the lines outlined above, a good deal could be accomplished in the way of prevention and many valuable lives would be saved this season.

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**FANCY TATTOOING.**

While it is generally recognized, for obvious reasons, that the practice of tattooing is capable of communicating disease; also that actual occurrences of such communication are on record, no-

tably cases of syphilis, it may be somewhat surprising to note that this same tattooing has been suggested as a means of prophylaxis!

The story of what prompted the suggestion is entertaining if not instructive.

A Japanese observer came across a man who presented a secondary syphilitic eruption of a pronounced character. So far, nothing strange. But this man had had, two years previously, a magnificent serpent tattooed on his arm, the back of the snake being of a rich blue color and its belly of a brilliant red. Again, you may think, nothing wonderful about this in a land wherein much tattooing of that description is practiced. The fascinating part of the story consists in the fact that whereas the tattooed arm was well covered with the specific eruption, including the blue back of the serpent, the latter's bright red belly escaped all maculation and papulation.

Now to solve the mystery. The Japanese observer is up on scientific research, if on anything. The customary and docile rabbit was called in. His scrotum was tattooed half and half with the two substances used to party-color the snake and a month later each side was injected with equal doses of a powerful spirochete infected substance; on the blue side, treponema-bearing ulcerations followed as thy should; on the red side, nothing.

If paper was not high we might try to entertain you at length with an account of the various experiments and tests which followed before a conclusion was reached; not only expense forbids, but we are sure you, dear reader, are most impatient to reach the solution of the riddle and we shall tell you at once: mercury, that's all. The red coloring was due to cinnabar which successfully protected the red tinted skin against invasion by the spirochetes.

With sufficient imagination it is not difficult to conjure up the artistic as well as prophylatic possibilities of fancy tattooing. The salts of mercury are numerous and their shades are various. Properly situated and skilfully executed such tattooed designs, it is suggested, might well yield efficient protection and prove to be a joy forever.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### MEDICAL TREATMENT OF GALL-BLADDER DISEASES VERSUS SURGICAL.\*

By DR. A. L. LEVIN

Franklin W. White of Boston, in a recent article on modern examination of the stomach, uses the expression, "we are in a transition stage; old methods are being discarded and new methods used." We can probably apply the same expression to the diagnosis and treatment of gall bladder diseases.

This paper is one of comment on the up-to-date method of tapping the bile exit region in the duodenum. The subject is rather an unfamiliar one to a number of medical men. My experience with this new method for diagnostic and therapeutic purposes for a period of over a year, applying it to a large number of cases with gall-bladder disease, has quite an encouraging feature and I am here to invite the attention of both the internist and the surgeon.

Einhorn must be acclaimed the pioneer who succeeded after many years of trying efforts to reach and explore the unknown field of the duodenum. He first described his method in 1909 and laid a great deal of stress on its importance from a diagnostic standpoint. He then remarked and repeated the same statement a year ago discussing my paper on duodenal lavage, that ordinary individuals where the gall bladder is not diseased have a clear golden yellow bile. If we find it turbid and greenish or thick, that indicates disease. Einhorn did not lay stress on draining of the gall bladder from a therapeutic standpoint, nor did he make mention about the possibility of studying the bacteria and probable usefulness of auto-genous vaccine.

In May 1918, (*Med. Rec.*), Einhorn gave us an indexed chart of the various abnormal colors of the bile. Of 24 cases examined, 18 had cholecystitis with turbid bile, in 8 of those stones were

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\* Read before the Orleans Parish Medical Society Nov. 8, 1920 at the Miles Amphitheatre, Charity Hospital.



found by operation. In 1 case, the bile aspirated from the gall bladder during operation represented exactly that which had previously been obtained by duodenal aspiration. I can corroborate his statement; in several of my cases the surgeon obtained the same character of bile as I obtained by the duodenal tap.

In Oct. 1918, (*Med. Rec.*), Hemmeter confirmed Einhorn's observations in duodenal intubation and adds his own mite to it as follows: "green bile is pathologic, greenish yellow and turbid portends a diseased gall bladder, frequently containing gall stones. The bile may, however, be golden yellow notwithstanding the presence of gall stones." He further states that a marked diminution in the alkalinity of the duodenal contents is a significant sign of disease of the gall bladder. Normally, 100 cc. of bile should be neutralized by 5 cc. n/10 NaOH. If it falls below 5, we can assume that the pancreatic juice and the bile are prevented from entering the duodenum. A marked presence of mucus speaks for a duodenitis or inflammation of the gall-bladder and the bile ducts. Hemmeter speaks also of the bacterial side of the bile and the serum therapy, quoting Rosenow who claims that sometimes bacteria cannot be demonstrated in the bile, but can be isolated from the walls of the gall-bladder or the center of the stone.

Jutte's modification of the tube and the method as described in the *Jr. A. M. A.* (Feb. 22, 1913), has greatly facilitated the mode of entrance into the duodenum. In the last several years, the study of the secrets of the duodenal contents which contain vital fluids to maintain the human machine, became a vital subject in medicine.

In 1918, Meltzer explained his theory of contrary innervation as applied to the gall bladder and sphincter muscle of Oddi, that is when the gall-bladder contracts, the sphincter muscle opens up and vice versa. The entrance of food into the duodenum brings about such a physiological act and Meltzer demonstrated that the same can be accomplished by douching the region with a 25% magnesium sulphate. This theory appealed very strongly to Lyon of Philadelphia, also Refhuss, who are to-day the principal enthusiasts in that field, the former especially. The new method, then, of the medical drainage of the gall bladder has become a reality. This paves the way for the invitation of the internist's and surgeon's attention.

That surgery of the gall bladder tract is not always an absolute

success, the surgeon himself will admit. Mayo's statistics show that 15% of operative cases are failures. Besides that, does a cholecystectomy affect in any way the efficiency of the rest of the digestive machine? Hohlweg, (*Prog. Med.* Dec. 1913) studied 42 cases of cholecystectomy and noticed a subacidity in 83.3. He then produced the same phenomena in dogs after the removal of the gall-bladder. Animal experimentation further proved, as stated by Rost, that the secretion of bile and gastric juice is affected greatly after a cholecystectomy, being two-thirds less in quantity. Kemp demonstrated that the bile is lower in alkalinity before reaching the gall-bladder. This would probably explain Hemmeter's contention that a marked diminution in the alkalinity of the duodenal contents is a sufficient sign of the presence of disease of the gall-bladder. Ohly, quoting Leed in *Northwest Medicine*, found that the loss of the gall-bladder in from 70 to 80% showed an acidity and achylia. He studied 39 cases of this type. In another group of 45 cases with occlusion of the cystic duct or considerable shrinking of the gall-bladder, there were 84% achylia and 14% below normal. Leed believes that there is probably a loss of a hormone which otherwise stimulates HCL secretion and duodenal acid chyme in turn stimulates the liver cells and the pancreas to greater activity.

In view of these facts which I briefly reviewed, the surgeon should follow a more rational procedure and preserve gall bladders that seem capable of functioning. Hemmeter is of the opinion that the so-called early operations in gall bladder disease have in general been given up and the special field of the surgeon is the chronic recurrent cholelithiasis, the infectious cholecystitis and chronic obstruction of the biliary ducts.

As to primary cause of gall bladder disease, the best authorities agree that the infection travels through the portal veins, through systemic blood, through the lymphatics, through the serosa from an infected peritoneum and last but not least, by an ascension of infection through the common bile duct from the duodenum.

Cases of catarrhal jaundice which we often see and which develop after a severe cold, acute gastritis and duodenitis, or after an attack of other infectious diseases, are caused, according to Lyon, by an extension from a gastro-duodenal catarrh. The pathology in such cases is explained in the following manner: The mucous

membrane at the ampulla of Vater becomes swollen and the exit is plugged up. Osler and Eppinger have found this to exist in the autopsy findings of individual reported cases. Such a change will often produce symptoms that might closely simulate an attack of gall stone colic. It is wiser to use the term "gall bladder trouble" when explaining to the patient, than feel confident that we positively deal with gall stones. The frequency of gall-bladder trouble and the difficulties we encounter in handling it are well known facts. This new method of draining of the gall bladder will solve the problem to a great extent. It is advisable that in any case with a history of gall bladder trouble, a duodenal tap should be made from a diagnostic standpoint. If one wants to ascertain the presence of bacteria, besides the color and consistency of bile, he can follow the method outlined by Lyon. The necessary articles are sterilized, the nose is sprayed with Dobell's solution, the throat should be gargled with potassium permanganate ( 1 gr. to the oz.), the stomach is washed with antiseptics and then duodenal intubation follows. I have modified the procedure and use my own so-called driving-in and massage method. It is not necessary to give the patient a quantity of water to drink when the tube is introduced; Einhorn is right in stating that it is not the water that drives in the tube but the muscular contractions of the stomach; I therefore stimulate muscular contraction. Putting the patient first on his back and massaging the stomach region from the cardia towards the pylorus, the gall bladder region is then massaged, the patient being instructed at the same time to take deep inspirations. Patient is then turned on the right side, the tube hangs over the edge of the bed and contents allowed to escape; the introduction of water by the syringe, it seems to me retards the flow of duodenal contents and bile because it drives the current backwards; it is not always necessary to use magnesium sulphate; another point that I have found out by experience is that sodium sulphate will accomplish the same as magnesium sulphate. If the flow does not start shortly, repeat the method of massage, give the patient half of glass of hot water to drink, instructing him to take deep inspirations. I found this method very successful in starting the flow of bile quickly. I introduce the tube through the nose which is less disturbing to the patient and use a tube of my own design which has a velvet eye, the openings are oval and larger than in the Jutte tube, there



is no metal bucket to cause irritation and the quality of the rubber is such that there is no need for a styilet. The method has been quite successful in a number of cases both from a diagnostic and therapeutic standpoint. It is being recommended already by our modern leading teachers in medicine such as Barker in his recent article in the *A. M. A. J.* I wish to report the following interesting case:

Mrs. M. H. 53, with a negative past history began to complain with nausea, lack of energy, loss of appetite and loss in weight. After 4 months of ill feeling, she began to suffer from violent periodic attacks of epigastric pain and finally daily vomiting. For a period of 6 weeks, she vomited daily after each meal. The pain was so severe that it would require large doses of morphia to quiet her and the attacks would come about twice a week. In the intervals, there was a constant soreness. On examination, a marked icteroid tinge of the skin and eyeballs was noted; the epigastrium was very sensitive to the touch and rigid. Blood pressure was low, temperature normal; urine was negative. Gastric analysis showed a subacidity. I saw the patient during an attack and the suffering was so great that it required 3 doses of morphia to quiet her. The evidences were very strong that I was dealing with a case of gall stone colic, advised an operation but the patient was reluctant in consenting, in fact I had the patient at the hospital for that purpose but was unable to secure a bed for her. I then decided to try duodenal tap, I did not succeed the first time, but on the second attempt using a 50% magnesium sulphate and hot water I succeeded in unplugging the ampulla of Vater; 8 ounces of a thick, black, molasses-like substance was drained off; patient was relieved immediately and she stopped vomiting. I continued the tapping for about a month every other day and it was interesting to note how the bile became clearer from time to time. Patient is at present the picture of health, has gained 30 pounds in weight and there is no recurrence of the former trouble for a period of eight months.

The following case demonstrates the efficiency of this method of treatment in a case of surgical drainage of the gall bladder with recurrence of symptoms.

Mrs. R. H. G. 39, for many years stomach trouble, pain cramp-like in character under the right costal arch, at times dependent on food with intervals of freedom from pain. After many months of futile treatment, a diagnosis of chronic appendicitis was made. She was operated on Sept. 24, 1918, appendectomy and gall-bladder drainage was done. For a period of about one year after operation, she was free from symptoms. About a year ago, she began to suffer from the same epigastric pain, nausea, heartburn, sour regurgitation and as a result of all this, a few nervous manifestations had developed such as insomnia, nervous eructation, etc. No loss in weight, appetite good but afraid to eat; bowels regular. Physical examination was negative except for a very sensitive spot at the upper third of the postoperative scar. There was a slight icteroid tinge to skin and sclera. Bile was obtained easily by the



duodenal tap which showed marked evidences of a still existing cholecystitis. The medical drainage treatment was instituted. Twelve treatments were given on alternating days with very marked improvement of all symptoms. The interesting point in the above case was the ease with which bile was obtained; in most of the treatments, bile started to flow freely in from 5 to 7 minutes, on one occasion 15 minutes. The nasal route was the method of choice.

A number of interesting cases treated by the above method with very satisfactory results could be cited, but for the sake of brevity I will submit the following table of a group of 22 cases :-

	Percentage.	
Total number of duodenal taps for entire group...	220	
Diagnosis confirmed by operation.....	3	13
Improved, no recurrence .....	6	27
Not improved .....	2	9
Recurrence .....	3	13
Advised operation .....	2	9
Still under treatment.....	6	27

Cases which do not improve in spite of persistent treatment should be referred to the surgeon for a more radical treatment. This in itself is a point of diagnostic importance. Those cases in which there was a recurrence was undoubtedly due to the brief period of treatment which was evidently not sufficient. This brief resume, I trust, will stimulate enough interest among the local medical profession so that efforts will be directed towards making further observations in this new field of medical endeavor. I wish to use this medium to express my appreciation to Dr. E. D. Martin for his suggestions and encouragement to select the nasal route and modify the tube.

#### DISCUSSION.

**Dr. Parham:** I am very glad Dr. Levin has brought up this subject for discussion tonight.

I have been much impressed with the recent work on the duodenal tube, particularly with that of Dr. Lyon as detailed in the October number of the *American Journal of Medical Sciences*. After quite a large experimental and clinical work with the duodenal tube, he has become convinced, and I believe has demonstrated, that much can be done, both therapeutically as well as diagnostically, in diseases of the gall apparatus. I believe, indeed, that many of these cases can be withdrawn from the field of surgery by a judicious use of the duodenal tube.

I think, further, that this work has taught us that we should not be content with operation in these cases, dismissing our cases as cured,

when many of them, will return later complaining very much as before operation. These cases should have the benefit of a duodenal investigation and, if necessary, appropriate treatment by duodenal lavage. Some of these do not get well, as shown by Lyon, because there is residual infection, and this may be benefited by the use of the Jutte tube. I think the cases reported by Prof. Lyon and those presented here by Dr. Levin tonight show unmistakably there is here an inviting field both diagnostically and therapeutically. I congratulate Dr. Levin on his persistence with this method in spite of much discouragement. Personally, I wish to thank Dr. Levin for the instructive manner in which he has presented a most interesting subject.

**Dr. E. Denegre Martin:** My own experience with the Jutte tube convinces me that there is much good in the procedure as described by Dr. Levin. I was a great sufferer from pylorospasm for many months, but nothing gave me more than temporary relief until I submitted to duodenal lavage. I was entirely free of the annoying symptoms after the second treatment and further relieved of gastric disturbances by subsequent treatment. Whether this method would have cured me entirely I do not know. I had my gall-bladder drained, not so much because I believed it necessary at the time, but because there was a history of heredity which made the symptoms doubtful and I wanted this doubt cleared up. I am thankful to report the special diet is a thing of the past and my health is not only restored but my gall-bladder intact, for which I am duly grateful. I can also testify to the great relief given patients by Dr. Levin, whose gall-bladders had been removed and who suffered from the most distressing and annoying symptoms. Be the criticisms what they may, the facts remain.

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### INFANTILE DIARRHEA.\*

By JOHN SIGNORELLI, M. D.

Nothing basically new can be offered on this subject, and yet the mere fact that both the number of cases and the number of fatalities fail to show any appreciable diminution generally, can be taken as evidence that in spite of the enormous amount of effort on the part of the profession the problem generally speaking still remains unsolved. I must in the same breath qualify the statement to some extent lest misinterpretations be applied; infants or groups of children whose environments and feeding are efficiently supervised have shown and do show that not only the relative number of cases but also the mortality is reduced.

And herein lies the fundamental basis which is to point out to us the road to a solution of the problem of so-called Infantile

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\* Read before the O. P. M. S., November 22nd, 1920.

Diarrhea. Looking into the matter of causative factors we find that failure to institute and maintain throughout the year a proper regime of feeding undoubtedly ranks foremost, for by this neglect there results even in the apparently well nourished child, a lowered resistance of the alimentary tract; closely applied to this I should say ranks the environments of our cases and the intelligence of the mother or guardian, for they have to do directly with the increased ease of introducing infection; and next I should place climatic influences and primary diseases of whatever nature, all of which by lowering the general comfort and body resistance of the baby throw in the deciding element necessary for the development of a true diarrhea.

Thus we see that the scourge of this Summer Diarrhea visits our baby population with such steady regularity that especially among the laity it has come to be accepted as an inevitable pass in the growing baby.

That the disease is infectious in character has been proved and clearly settled; several organisms or groups of organisms may be found, but from the above remarks it is clear that the diarrhea is in reality always a secondary condition—secondary to a definite disorder of milder and non-infective type; secondary to errors of feeding during the milder months; or, secondary to acute infectious diseases. The observations play an invaluable part in helping to decide what course should help to arrive at a solution, and I shall here state my experience, which tho limited so far, is encouraging indeed for ultimate effective teaching.

The St. Vincent Orphan Asylum has a baby population of about two hundred, ranging in age from birth to five years and here I found the records to show that each summer a percentage of cases entirely disheartening succumbed to the ravages of Infantile Diarrhea in its usually various manifestations. At the beginning of the summer 1919, I decided to divide my nursing babies into three classes; one to be fed on condensed milk; one on the routine found there when I took charge, namely, buttermilk; and the other class on percentage modification of whole milk. The babies were allotted in rotation so as not to discriminate in the matter of their previous health and development. My desire was to establish to what extent a particular type of food was responsible for the occurrence of this disease and for that reason all these babies were closely watched



and given immediate attention at the very start of the slightest nutritional disturbance. No case was permitted to go 24 hours without attention to management in curtailing the food supply and instituting therapy. Our efforts were amply rewarded in discovery by comparison of figures with previous years that our morbidity and mortality were reduced by 11% and 5% respectively. More striking still is the fact that these cases have been about equally distributed in all the three feeding classes.

These experiences are practically duplicated in a comparison of figures between the babies whose feeding is supervised in the ambulatory Clinics of the Child Welfare Association and those of sections of the City not so supervised. Here the figures show that the mortality for the rate for the former is 3%, against 11% for the latter. Speaking for the clinics I have under supervision I can say that the cases are not fed on any one set of formulas, or on any one type of food. So that here too, the results obtained cannot be credited to one or other food, but directly to supervision and training of the mothers and guardians.

Contrasted to this evidence, in a recent article\* on the subject, I pointed out that statistics compiled from the records of the Charity Hospital show no decrease in the number of cases or deaths from this cause from 1914 to 1919 inclusive. It is not necessary to remind ourselves that cases coming to the Charity Hospital are not those fortunate with supervision or hygienic environment.

Such striking results, though the work yet has not extended over many summers, can not fail to illustrate that conservation of child life can be affected to an encouraging degree by our efforts against this disorder which is responsible for the loss of child life in a greater degree than any other condition we know of. They show that it is not in the adoption of a particular food, or of a particular set of formulas, but rather in education as to hygienic treatment, in the necessity of avoiding improper feeding at any stage of the life, and more important, in the prompt and efficacious management of every intestinal derangement in its incipience, that we can hope to find a solution of the problem.

The important question these results raise is whether our private patients can be made to benefit therefrom. Is it, or is it not possible to exert more time and effort in this direction? I, for

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\* Signorelli, John. Infantile Diarrhea, *The Charlotte Med. Jour.*, July, 1920.



one, am of the opinion that much can be done, and I shall feel amply repaid for my efforts in this talk if it will be answered by increased efforts on the part of the profession in the direction of proper instructions to mothers for correct feeding; for maintaining this correct feeding throughout the year and not wait for the resistance-lowering season to approach; and for impressing them with the danger of neglecting an apparently mild nutritional disorder and for the necessity of medical attention early in the disease.

#### DISCUSSION.

**Dr. Fenner:** I have been deeply impressed by the statistics the doctor has given in regard to the mortality in infants under 12 months of age. Years ago I had charge at St. Vincent's, and gave the most earnest care to those children, even preparing their milk formulas myself, but we had no such results as he appears to be getting. Apparently nothing startlingly new has been introduced in the methods of feeding as compared to the practice in my time, but the mortality then was practically between 95% and 100% in babies under a year old. By this I mean the final mortality, for we all know how infants taken sick with "summer complaint" may recover from a first or even a second attack, but finally succumb during September, or the early part of October. In my experience, practically every bottle fed baby less than a year old ultimately became a mortality.

Profoundly discouraged by my own results in this class of children, I investigated the results in other institutions, and was to some extent consoled by finding that their experiences were almost the same as mine. At the great infant asylum in New York, the Head Sister told me that until she introduced a general system of breast feeding for infants they all died. At the Asylum near Boston, which had recently been the subject of violent newspaper denunciation, an entire new staff of physicians, a corps of trained nurses, and a Walker-Gordon milk laboratory had been installed in the effort to improve the fearful death rate, but at the time I visited the institution the attendants were forced to confess to me that little had been accomplished. Inquiry of the Head Sister, who had formerly served in the Infants' Asylum in Albany, developed the fact that her experience had been identical there: the mortality was above 95%. I became convinced that institutional mortality was everywhere discouragingly high. I recognize that the educational efforts of the infant welfare associations has done much good, but I can hardly bring myself to believe that any such miracle has been accomplished as would appear from the statistics just given.

In connection with the spread of these infectious diarrheas in institutions, I recall a visit I paid years ago to the clinic of Prof. Heubner in Berlin. He had installed in some of his wards glass partitions between the babies' cribs, and claimed to have seen marked diminution in the spread of infections, particularly of the lungs, where these partitions were in use. We all know how such bed isolation was insisted upon in the army during the late war, and I am convinced that here we have one of the measures which might be well introduced in the prophyl-

laxis of infectious conditions, whether pulmonary or diarrheal, in the young.

**Dr. Hamilton Jones:** I wish to express my appreciation of the paper and of the work of Dr. Signorelli, but to my mind too much stress cannot be laid upon the fact of "fly control." Swatting the fly and screening has a great deal to do with the suppression of the spread of summer diarrheas. In former years it was believed to be an air-borne disease, but we now realize it is largely a "fly-borne" disease.

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## A DEMONSTRATION OF THE TECHNIQUE FOLLOWED IN THE DETERMINATION OF THE BASAL METABOLISM RATE—INDIRECT METHOD USING THE BENE- DICT PORTABLE UNIT.\*

By HAMILTON P. JONES, M. D., Internist "Diagnostic Clinic" New Orleans.

The apparatus here shown which I purchased and have had in constant use since last spring was designed by Prof. Francis T. Benedict in charge of the Carnegie Nutritive laboratory at Boston, and, while it is an ingenious and beautiful instrument, there is not a patented part about it, and all that he has contributed has been donated to its users as a free gift out of hand, and I take this opportunity of giving him this credit and appreciation. The determination of the Basal Metabolism rate is the most recent example of the passing of purely scientific procedure into general clinical application, and it is hoped that it, one of the most difficult technically—will not be thrown into discredit by a neglect of the details essential to obtaining a true Basal Metabolism rate.

The average normal human temperature is about  $98 \frac{3}{5}^{\circ}$  F. whether he be at the North Pole, the Equator, at work or rest, manifestly varying amounts of energy are consumed—and heat produced—that are not recorded by the thermometer. The boiling point of distilled water in an open vessel at sea level is  $212^{\circ}$  F. no matter whether the boiling is produced by a small or large source of heat, one, three or ten Bunsen burners; but it is manifest the thermometer gives no information as to the amount of energy going through the water.

The glands of internal secretion have much to do with the rate of energy or heat production, especially the thyroid gland. Insufficient secretion causes a diminution in the rate of heat produc-

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\* Read before the O. P. M. S., November 22nd, 1920.

tion—just as a low fire will cause the open pan of water to just simmer. A condition found in Myxedema. Sufficient secretion causes oxidation to go on at a normal rate, like the brisk boiling in the open vessel, a condition found in health. Excessive secretion causes the oxidation to go on so violently as to rapidly consume the food stuff taken in and the body reserves, similar to the violent boiling of a vessel of water on a too hot fire, a condition found in toxic goitre. There is no way to determine the energy used by the body except by determining the Metabolic rate.

The minimum heat production of an animal—12 to 18 hours after the ingestion of food and with the animal at complete rest is what is known as the Basal Metabolic Rate.

The minimum heat production may be determined directly by actual measurement by means of a Calorimeter, or indirectly by calculating the heat production from an analysis of the end products which result from oxidation within the organism—or specifically from the amount of oxygen used, and the corresponding amount of carbon dioxide produced together with the total nitrogen eliminated in the urine.

The importance of oxygen was well understood by Lavoisier who, in 1780, named and identified the gas; but only within the past decade, and especially since the close of the war has it been recognized that there was a comparatively fixed requirement for oxygen, and also for the vital capacity of the lungs, in direct proportion to the height and weight of the individual in health—and varying to a marked degree—in certain conditions of disease. The oxygen requirement varying most notably in diseases of the organs of internal secretion—especially the thyroid—and the vital capacity notably in pulmonary tuberculosis.

It has been found that for all practical clinical purposes that either the direct or indirect methods of Calorimetry give results so closely parallel as to make it a matter of equipment and convenience rather than one of outweighing merit of one method over the other. And as the value of Clinical Calorimetry is so tremendous, it is important that this method, giving good results—that will be most available to the greatest number of patients, is the method of choice.

Normal standards—naturally standards of comparison are essential—because it is necessary to know the Normal Basal Metabolic rate so that an abnormal one could be recognized. As a result



of this the unit taken was one square meter of skin surface. Naturally the skin surface of no two people is apt to be the same, so that Eugene F. Dubois and Delafield Dubois—after carefully measuring the skin surface of a great number of people of different ages, sexes, shapes and sizes found, that there was a sufficiently accurate relationship between the standing height and weight of a human body, to the skin surface, to enable them to construct a formula.

$$A = Wt + .425 \times Ht + .725 \times 71.84$$

A=the Surface area in Sq. C. M.

Wt=the weight in Kilograms

Ht=the height in Centimeters and

71.84 is a Constant

On the basis of this formula they constructed a height-weight chart, by means of which the surface area can be determined at a glance.

The skin surface area unit seems to be the most satisfactory unit yet put forward and upon it a series of normal basal metabolic rates have been established for the various ages and sexes.

It has been found that the basal metabolic rate is less for females than males and that in both sexes there is a lowering of the basal metabolic rate as age increases. It must of course be recognized that there is no inflexible standard for normal metabolism for any given age, weight, height and sex from which all normal individuals never vary, however, if they do materially they are the exception, as they would be should they vary normally, in heart rate, blood pressure or temperature, and we must recognize that there are such cases.

These exceptions are so rare, and the accuracy of basal metabolic ratings, when properly made, is so great that we must look for some pathological condition wherever there is a variation beyond say arbitrarily 10% either way.

So much by way of introduction and determination of standards. Now for the determination:

*Post Absorption Period:* Patient must have taken no food for at least twelve to eighteen hours, as the energy required by digestion is enough to upset the value of the observation; for that reason it is more convenient usually to make the patient report to the clinic in the morning. Muscular activity—the least muscular activity on the part of the subject causes an error in the reading



of the rate, so delicate and accurate are these determinations, and should they occur, note should be made of them and the work repeated if the effect of these movements cannot be evaluated.

*Preliminary Rest Period:* It is my custom to have subjects loosen articles of clothing and to rest on the table or couch, upon which they will be during the observation for at least thirty minutes before the test begins. It makes very little difference whether they are semi-reclining or laying flat, so long as they are at rest and comfortable.

*Effect of body temperature:* Any elevation above 90° F. so disturbs the rate that the determination is of questionable value and had best not be made, as so far no way to discount abnormal temperature has been devised.

*Character of respiration* should be normal and patient should be at mental rest as well as physical.

*Records* should be kept accurately and at the moment—to trust anything to memory is fatal—and checks should be made by duplication of tests.

The Benedict apparatus is a closed circuit device into which the patient breathes back and forth; this may be accomplished by use of a tissue mask, a mouth piece and nose clip or in various ways, as the determination is one of oxygen consumed. It has been found not necessary in general clinical practice to determine the urea, nitrogen or the CO<sub>2</sub> output—or respiratory quotient. Any leakage is charged up to the patient, and as the apparatus is filled with pure oxygen—the slightest loss is correspondingly magnified—so the machine must be tested for leaks. The connection having been made the motor driving the force fan is started, and the three-way valve having been closed, the oxygen driven from the gasometer bell—which rises up and down with each respiratory movement—through a jar of soda-lime which absorbs the CO<sub>2</sub>. From the soda-lime jar it goes to the mouth piece, and then back to the bell under a pressure equal to about  $\frac{3}{4}$ -inch of water.

As air is inspired the bell goes down, as it is expired the bell goes up, and, as the end of expiration is more regularly recorded, all observations begin and end at the end of expiration.

This gasometer is calibrated in ccs. So that the number of c. c. in the bell is noted at the beginning of the period of usually ten minutes, and at the end. The difference between these two readings gives the amount of oxygen consumed.

In the Benedict apparatus it is only necessary to make two cor-

rections—one is for temperature and the other is for barometric pressure that is to refer the gas to a temperature of 0°C—and a barometric pressure of 760 M. Metres of Mercury.

Inasmuch as we are at sea level in New Orleans I have found that our barometer stands close enough to 760 M. M. of Mercury to render the correction negligible.

Our temperatures are high enough especially in summer to cause a necessary correction of as high as 10%. This is effected in the following manner. According to "Charles' Law," which states that, provided the pressure remains constant, the volume of a gas will change  $1/273$  of its volume at 0°C for each degree C. of change of temperature.

Protein Respiratory Quotient is .80. Fat Respiratory Quotient is .71. Carbohydrate Respiratory Quotient is 1.00 average .84. Calorific value of 1 liter of Oxygen when Protein is burned is 4.485. Calorific value of 1 liter of Oxygen when Fat is burned is 4.686. Calorific value of 1 liter of Oxygen when Carbohydrate is burned is 5.047. Calorific value of 1 liter of Oxygen Mixed diet is burned is 4.85.

For a respiratory quotient of .84 the calorific value of 1 liter of oxygen is 4.85 using the value of the non-protein respiratory quotient. Therefore, the number of calories produced per hour will be the number of liters of O consumed per minute x 60—x 4.85. This divided by the number of square metres of skin surface gives the number of calories produced per hour per square meter of skin surface or the basal metabolism. This compared with the normal for sex and age gives the basal metabolism rate. The heat production or metabolic rate, is concomitant with work accomplished; it is an indication of the rate of oxidation and cannot be estimated by taking the temperature of the subject.

#### ILLUSTRATION RECORD OF A SUPPOSED CASE OF MYXEDEMA.

Name: Mrs. K. Height, 60  $\frac{3}{4}$  inches (154 cm.) Age, 60 yrs. Service, Charity Hospital. Weight, 206 lbs. (93.7 kg.) Sex, Female. Diagnosis: Myxedema. Surface area, 1.92 sq. m. Normal cal. per hour, 34; T. 98; P. 84; R. 24; BP. 220

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Spirometer No. 72

	Period A.		Period B.	Barometer	760 C. M.
Spirometer Start	7400	Start	6200	Temperature	30° C.
Spirometer End	3800	End	3800	Temperature	30° C.
Diff.:	<u>3600</u>		<u>2400</u>		
Time, 9 minutes.			Time, 6 minutes.		

Average cc O consumed per min., 400 multiplied by Barom. and Temp. Cor., 9 is  $400 \times 9 = 360$ .

Divide by Sq. MS. A. is 360 divided by  $1.92 = 187.5$ .

Multiplied by Fact 4.825 is  $187.5 \times 4.85 = 929375$ .

Multiplied 60 Minutes per hour  $.9293 \times 60 = 55.76$ .

Cal. per sq. m. per hr., 55.76.

This divided by average number of calorics per sq. metres of skin surface per hour for age and sex gives the fraction  $\frac{55.76}{34} = \frac{164}{100}$

which is 164% of normal—164 minus 100 equals plus 64% which is Basal Metabolic Rate of this patient, in other words she was consuming 64% more oxygen per square meter of skin surface per hour than is normal which absolutely and definitely contradicts the clinical diagnosis of Myxedema. Is it really a case of Hyperthyroidism.

I have very greatly simplified the calculation and done away entirely with the use of logarithms by the use of the Slide Scale which enables by its use in conjunction with the tables mentioned above, the calculation to be made in three or four minutes after the data is in hand, so that the actual time of making the basal metabolic rate itself is rarely over fifteen minutes. The scale does not permit one however to calculate the skin surface by the formula; to do that requires the use of logarithms but it is comparatively infrequent that the charts do not cover the case in hand.

To show the usefulness and versatility of the application of basal metabolic ratings, I have appended the following brief notes.

Diagnosis	Age	Color	Sex	Ht.	Wt.	Basal Met. Rate	Thyroid Enlarged
1 Pellagra.....	41	W	M	165	48.2	44%	Yes
2 Pellagra.....	23	C	F	157	38.7	53%	Yes
3 Pellagra.....	32	C	F	158	41.1	5.5%	Yes
4 Pellagra.....	18	C	F	172	33.2	4.2%	Yes
5 Pellagra.....	34	W	F	164	59.6	13.5%	Yes
7 Pellagra.....	39	C	F	162	31.8	11%	Yes
1 Hyperthyroidism	20	C	F	154	33.9	76%	Yes
2 Hyperthyroidism	42	W	F	153	41.4	6.8%	Note
3 Hyperthyroidism	43	C	F	160	57.7	83.5%	Yes
4 Myxedema.....	60	W	F	154	93.7	60%	Yes
5 Myxedema.....	37	W	F	153	115.7	66%	Yes
1 Paget's Dis.....	50	W	F	153	35.	26%	No
1 Diabetes.....	33	C	F	171	95.5	14%	No
1 Suspected Acromegaly..	Normal—Not a Case.						No
1 Neurasthenia .....	34	W	F	155	50.5	49%	No

Note. (2) This case was treated 12 years ago with the X-ray for Hyperthyroidism and was severely burned about the throat, the scars of which she still bears. All these cases were taken from the wards of the Charity Hospital.

## OLD AGE.

It has long been known that the basal metabolism rate declines with the advance of years. With the end in view of determining the effects of small doses of the iodides on very old people, that is over 65 years of age, I made, three months ago, basal ratings on twenty old men and women whom I then put on small doses of the iodides—with the apparent effect of slightly increasing their basal metabolism rate, probably through the stimulating effect of iodine on the thyroid gland. This may in a measure account for the benefit so often noted in the administration of this drug to old people.

## SYPHILIS.

It very frequently happens that we are much disconcerted by a negative Wassermann in cases of heart disturbance, especially in the young, where we had rather confidently expected it to be positive. Much light is thrown on these cases by a basal metabolism determination, a normal rate pointing, in the absence of any focal infection, to the necessity of not only supporting measures, but the need of active anti-syphilitic treatment.

## NEURASTHENIA.

It often happens that cases present themselves with various symptoms, especially of tachycardia, trembling and nervousness where it might be difficult to determine whether it is a case of neurasthenia or thyroid disturbance, or a case of cardio-vascular syphilis or thyroidism. The basal metabolism rating will often clear the diagnosis.

Although it must be remembered that two or more pathological entities may co-exist. The following case was taken from one of the neurological wards, with a diagnosis of neurasthenia: Mrs. S., aged 34; the thyroid while enlarged was not markedly or notably so; the basal metabolism rate was found to be + 49%. In reality it was a case of toxic goitre.

## FOCAL INFECTION.

Naturally in every case, no matter what its nature, may be foci of infection should be cleaned up. And it is particularly interesting to note the improvement in the basal metabolism rate in cases



of hyperthyroidism after the removal of diseased tonsils; bad teeth, etc.—this does not occur in all cases—and I have never seen the removal of focal sources of infection entirely restore the metabolic rate to normal, but their removal if possible should always be undertaken before the thyroid is treated. It is not uncommon to see the rate fall 10%, with a corresponding amelioration of the symptoms.

#### PELLAGRA.

Much has been written concerning this disease, and it has been more discussed and possibly almost as vigorously studied and worked on in the south as malaria.

The concensus of opinion of a very strong body of men is that it is essentially a dietetic disease, brought about largely by a diet deficient principally in vitamins leading to faulty metabolism. While most extensive feeding experiments were carried on, with both balanced and unbalanced rations suitable and unsuitable, overabundant and deficient, and the metabolism studied in a broadly dietetic sense. I believe that I am the first one to publish any data on the basal metabolism rates of individuals suffering with this disease—and the results have been most interesting and I think illuminating.

Here we have seven cases of pellagra all with a basal metabolism rate above normal ranging from 53% to 42%. Three had positive Wassermann reaction, two negative, and in one it was not reported.

Medication: Full diet, rest in bed in 2; Fowler's Sol. and special diet, 1; Quinine hydrochlor, Sod. cacodylate, Full diet, 4.

It will be noted that the administration of quinine was apparently without effect on the metabolic rate.

Judging from these observations—even though they be on a limited number of cases, seven in all—it must be remembered that they were the only seven available and therefore could not have been picked; it must be recognized that there must be an unusually high incidence of thyroid disturbance in this disease, which is of an active character as shown by the uniformly increased basal metabolism rates found.

The question of course arises, and it is not solved in my mind, as to whether the thyroid disease has to do with the pellagra or the pellagra acting as a focal infection would predispose to a thyroid gland complication.

This opens up the whole subject of pellagra again from an en-

tirely new view point and also points to the advisability of trying out the effects of therapeutic application of the X-ray to the thyroid gland just as would be followed in the X-ray treatment of exophthalmic goitre.

#### HYPERTHYROIDISM.

Basal metabolic rate invariably increased during active stages of the disease, to be followed gradually, in those cases medically treated or allowed to get well spontaneously, by a lowered rate, at times to below normal after the passage of years, although the gland may be enormously enlarged, and the rate may become so lowered secondarily as to call for the administration of thyroid extract. This is also true of post operation and over treated X-ray cases.

The thyroid disease metabolism rate raises directly with the degree of activity of the secreting portion of the thyroid gland. Therefore toxicity (hyperthyroidism) is indicated by the clinical symptoms rather than the size of the gland. A small gland may be highly toxic, while a gland large enough to cause unsightliness and pressure symptoms may not be secreting enough to carry on the normal metabolism of the body, in other words, there is nothing to gauge the nature and character of your thyroid condition except by the clinical phenomena produced or the making of a basal metabolism determination, and the latter is one of the few procedures in clinical medicine which gives the answer in percentages, comparable, one case with another, and the results of which are so far removed from the peradventure of a doubt—no one has the right to treat a case of goitre trouble without making basal metabolism determinations. I recently made a 4 months post operative basal metabolic rating on a man who had been operated on for hyperthyroidism—the rate was—16.5%. Microscopical diagnosis was adeno-carcinoma of the thyroid. Does not this point to the necessity of a consideration of possible malignancy in a rapidly growing thyroid mass with a low metabolic rate?

Even with the greatest experience and clinical acumen the best of us are shown wrong in clinical diagnoses of thyroid conditions, and there is no doubt that many a thyroid has been removed to the definite hurt of the patient; that many a case of toxicity has been made worse by the administration of thyroid extract, or iodine; that many a case of hypothyroidism (myxedema) in mild form has gone unrecognized—and that these poor people have been allowed

to drag along without the energy to undertake anything unusual, except to be called neurasthenic or what not, finally to drift into some don't worry, rest advising cult.

*Certainly no surgeon has the right to operate without knowing what he is operating* for nor has any one the right to use the X-ray any more than the knife until it is known what it is being used for in thyroid disease, and I will go further and state that no one has any right to treat any condition of the thyroid whatsoever without knowing what the basal metabolic rate is.

Following the work of others I have treated a number of cases of hyperthyroidism with the X-ray—always regulated by basal metabolism control readings—with, in properly selected cases, results that seem to be less attended with danger and satisfactory in outcome as those operated upon.

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## SOME SUGGESTIONS ON THE USE OF QUININE IN THE TREATMENT OF MALARIA.\*

By DR. O. W. BETHEA

*Foreword.* In reading the literatures on this subject, and in discussing it with many physicians from various sections, and observing the administration of quinine in hospitals, it has seemed to me that there was room for a brief presentation of some phases of this matter that might prove of interest—at least in stimulating discussion and encouraging further investigations.

I will not try to present the whole subject, but only certain points about which I wish to make suggestions.

*Specific value of Quinine alone.* During the recent war, some reports were sent in from Salonica and other points, claiming that quinine would not cure some cases of malaria observed. It is hardly fair for us to sit over here and dispute this, and claim that they were using an inferior product, or, that an insufficient amount was ordered, or that the patients did not take it. Bass, however, has conclusively proved that quinine alone, properly administered, is absolutely specific for all forms of malaria known to this section of the world.

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\* Read before the O. P. M. S., November 22nd, 1920.

*Duration of Treatment.* The various writers have uniformly agreed that there should be two periods of treatment:

1st. A period of intensive treatment lasting about three days, or until the subsidence of symptoms. This last clause is often overlooked and is one of the points I wish to emphasize. In cases characterized by tertian or quartian periodicity, I suggest continuing the intensive treatment through two chill days and until one period has been entirely missed, both as to chill and fever.

2nd. The period following the first few days of intensive treatment.

I think that we have no better plan than that worked out by Bass. That is, that this should be for a minimum of eight weeks and longer if indicated by clinical evidence, laboratory findings or a history of chronicity with a persistent tendency to recurrence.

*Amount to administer.* The statement is now rather uniform, that for the period of intensive treatment, 30 grains per day of a salt of quinine is the proper average dosage.

For children many tables have been submitted, based on age. My contention is that these suggestions are taken too literally, and the overlooking of an important consideration may account for many failures.

The idea of the treatment is to sterilize the blood (so far as the plasmodia are concerned), by producing a certain concentration of quinine in this media. So much quinine to so much blood. It would seem therefore, that the only criteria for arranging dosage is the amount of blood to be sterilized. If two buckets of polluted water were brought to you to be sterilized, and one bucket contained twice as much as the other, you would put in it twice as much of the disinfectant. We can consider the circulatory system of our patients as containers filled with blood, and age, sex, or any other such factors should be entirely eliminated from consideration. If a child brought you a bucket of polluted liquid you would not ask the age of the child, but, the amount of the material to be treated.

It reminds me of Dr. Feingolds suggestion on history taking, "When a man comes to you with a cinder in his eye, don't ask him what his grandfather died of."

In administering the drug to children the usual plan has been to apply Young's rule, which would give a child a year old, one thirteenth of the average dose, while a child of this age averages about one-seventh of the adult weight. Bass, Holt and others have



called attention to the frequency of the failure of treatment in children being due to insufficient dosage and have presented tables calling for larger doses for the various ages stated. Why the age at all?

As 30 grains of quinine is the proper daily dose for an average adult (about 150 pounds), I would suggest that we try to remember quinine dosage, as one grain for each five pounds of body weight, allowing for character of tissue anasarca, etc., if necessary.

There seems to be no evidence of any material difference in blood proportion in women and children as compared with men, so this rule may apply for all classes.

For the second stage of treatment, instead of arbitrarily remembering fixed adult and children dosage, I suggest one grain for each 15 pounds of body weight.

*Salt of choice.* The sulphate is used many times as much as all other salts put together. In commerce, the word quinine means quinine sulphate. Many authorities recommend it as "answering every purpose."

In administering a salt of quinine the quinine content is the part of value, and the acid radical is considered valueless except as rendering the alkaloid more readily soluble. Quinine sulphate is so sparingly soluble (1 to 725), that Bastedo and others urge that it be given after meals so that the acidity of the stomach contents may facilitate its solubility.

I wish to recommend the hydrobromide for oral administration for the following reasons:

It is readily soluble, (1 to 40).

It contains a full average per cent of the alkaloid, (76% as compared with 74% in the sulphate).

The acid radical of the salt is not entirely lost as the patient gets some benefit from the bromide radical. The bromides are the most efficient antidotes to the nausea and nervous phenomena of cinchonism, and it has seemed to me, that these unpleasant symptoms were some less where this salt is employed.

For intravenous administration a more soluble salt as the dihydrochloride is of course, indicated.

*Time of administration.*

As Bass, Henson, Heiser and others have conclusively shown that the sexual forms in all stages of their development are affected by quinine, it is to be regretted that many still do not begin the

administration of the drug as soon as the diagnosis is made, but wait until a certain number of hours before the next expected paroxysm.

By beginning treatment at once the patients tissues are conserved, the next paroxysm may be materially lessened in severity or entirely missed.

The administration during the period of intensive treatment may well be illustrated by selecting from the following articles.

Bass gives 10 grains, morning, noon and night.

Deaderick recommends 2 or 3 grains, every 2 or 3 hours, during the entire period, (day and night).

Solis-Cohen recommends two large doses, 8 and 4 hours before the expected chill hour.

The old plan still followed by many, is to begin about 6 hours before the expected chill, and give 5 grains every hour for 6 doses.

These, of course, being doses for the average adult.

I suggest individualizing these cases.

The plan of Bass certainly meets the requirements of the vast majority of cases.

I have found the plan of Deaderick of considerable value in certain cases with a tendency to cinchonism and in pregnant cases.

I have found some cases with an intolerance of the drug, particularly where nausea and vomiting were factors, when I felt that I secured better results by the fourth method mentioned. This resulted from being able to select one period of the 24 hours during which, rest in bed, ice bags, and empty stomach, and liberal doses of sedatives could be employed, when this would not have been practical for the whole time.

For continued treatment, often the first few days we find two plans still in use. The daily administration and the "Quinine days" of large dosage once or twice a week with no medication the intervening days. The bulk of evidence seems to favor the daily dosage and this is now usually given in one dose at bed time.

Repairing the damage done by the disease.

When a house partly burns, those concerned are not satisfied with putting out the fire, but repair the damage. I feel that the tendency is too much to cure the disease only, and to neglect to lend scientific aid in repairing the damage that has been done.

*Cinchonism.* There seems to be a tendency to regard this as a

matter of course. Much can be done to relieve the distressing phenomena of this condition, and I would particularly urge careful diet and the more liberal use of bromides.

#### DISCUSSION.

**Dr. E. L. King:** Dr. Bethea mentioned the cautious use of quinine in treating malaria in pregnant women. The authorities are divided on this question. The concensus of opinion is that quinine has little or no effect on the pregnant uterus, except during labor, at which time it occasionally seems to strengthen the uterine contractions. In our Obstetrical Service at the Charity Hospital we have treated quite a few pregnant women suffering from malaria and have not caused premature labor by the use of quinine.

We have adopted a system of combining ten drops of tincture of opium with each dose of quinine, on the theory that any irritation set up by the quinine would be counteracted by the opium. We are not sure that this is necessary, but it is at least worthy of trial. The usual quinine dosage is given and the method of administration does not vary from that employed in the non-pregnant.

**Dr. E. A. Ficklen:** The danger of administering quinine in pregnancy is possibly exaggerated, as Dr. King has stated. Personally, I have never seen labor induced by quinine, although I have known of two instances where very large doses were taken between the sixth and eighth weeks of pregnancy. For this reason I believe that it can be given almost with impunity where malaria occurs in pregnant women, yet I would state that the precaution of guarding the dosage with opium is a wise one.

I should like to ask Dr. Bethea whether he regards quinine as a proficient prophylaxis against malaria. Several manufacturing houses have been using the articles which appeared in foreign journals, on the inadequacy of quinine as a prophylaxis, as propaganda for their products.

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#### THE NUT.

By T. J. DIMITRY, M. D., with Apology to Walt Mason.

I firmly hold that I am sane, there are no wœvels in my brain; no bats nor bugs are wont to chase within my dome in endless race. But still, unfortunate I dwell and worry in my padded cell. I read and tried to understand a the'ry coined in Hunnish land. I read this the'ry thru and thru; the more I read the less I knew. I thought it over day by day; I dreamed it when I hit the hay. I asked one of them who ought to know, the simple truth to me to show. The laboratory workers said; this the'ry simply puts to bed all others for immunity. Tho' how this is I cannot see, a few, some

wise professors, wailed that this hypothesis had failed like things upheld by Hunnish brag, and then my brain began to lag. A certain friend in pity cried, for heaven's sake let Ehrlich slide; it takes a Hun to understand a thing so surely propagand(a); I replied, "Then I cannot dodge this guessing match of Hun hodge-podge; for I'm bound to find a clew to Ehrlich's curves before I'm thru." And this I did; for it now seems that Ehrlich shed his side chain beans in emulation of the group who brewed the propaganda soup. I thought the questions day by day and dreamed them when I hit the hay. They said I had a raving spell; and put me in this padded cell. The children come when school is o'er and feed me peanuts through the door, and rubbernecks come by and say "Alas, for this poor stricken jay;" The keepers murmur to each guest, don't mention Ehrlich we request, for he may rise in frenzied rage and tear the padding from the cage. I still maintain that I am right and willing to keep up the fight; immunity is hazy, its nomenclature is sleazy, a few sane and many crazy.

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## ABSTRACTS, EXTRACTS AND MISCELLANY.

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EPILEPSY A SYMPTOM OF SPLANCHNOPTOSIS. The fact that what is usually called epilepsy is constantly associated with displacements of the abdominal organs has now been demonstrated in 810 consecutive cases of the writer. This demonstration has consisted of, first, the clinical history and, second, the physical examination of the patient; third, the serial X-ray study, and, finally, in the majority, the surgical exploration of the abdominal cavity. This record, with the additional significant fact that the visceral condition is always antecedent to the convulsion phenomena, as shown by the earlier development of constipation, and the absence of both hereditary factors and extra-abdominal lesions, forces the conclusion that so called epilepsy occurs only as a symptom of splanchnoptosis. This conclusion is further confirmed by these observations and the daily observation of general practitioners to the effect that epilepsy is always associated with constipation; that the epilepsy is worse when the constipation is worse; and that the most effective, ready-at-hand relief from seizures is by laxatives. It was this fact, confirmed by surgical experience, that prompted



writing his first article under the title of "Constipation and Epilepsy" and upon which he based a second article entitled "The Probable Cause and Logical Treatment of Epilepsy." Later experience has shown that constipation while antecedent to and associated with the seizures in these cases is, like the seizures themselves, a symptom of splanchnoptosis. The mere fact that many people who have splanchnoptosis do not have so-called epilepsy does not invalidate the observed and here recorded fact that eight hundred and ten people who did have epilepsy likewise had splanchnoptosis and that the development of the splanchnoptosis was antecedent to the epilepsy. The explanation of this difference will doubtless sometimes be furnished through biochemic research. The basic fact is, that epilepsy is always associated with and is therefore a symptom of splanchnoptosis.

This basic fact is susceptible of verification at the hands of every practitioner who sees these cases and especially by every institution now acting in a custodial capacity to large groups of these unfortunates. To begin with, the cases must be *really* examined. This means that a thorough history must be taken. Then the patient must be stripped. The physical inventory should be carefully made, front and back, from head to foot. Special search should be made for possible foci of infection as ancillary factors in the case. The abdomen should be gone over, first, with the patient on his back; next, with him erect. A very little practice with abdominal percussion will enable the physician to detect the gastric note, the cecal note, the transverse-colonic note, sometimes the sigmoidal note. With the patient on his back, these notes will generally be found approximately in their normal positions, with the possible exception of the cecal note which in these cases will always be found low in the right lower quadrant, sometimes as low as Poupart's ligament. Now stand the patients up and it will be found that all of these notes, these separate areas of resonance, will have become obscured, more or less blended, by gravitation into the lower zone of the abdomen. The only note that does not thus migrate downward is that of the cardia which, however, is generally farther around to the left and toward the back. In other words, the viscera will have dropped. This examination is all very easy, very important.

Then all cases should be given an X-ray study. When done right it is very clarifying; when done wrong it is very misleading.

It is done approximately right when the following rules are observed: (1) The patient should be free from all laxatives or enemas for a tleast twenty-four hours before taking the barium meal; (2) the barium meal should be taken at 9 o'clock in the morning; (3) the first picture, to show the stomach and beginning duodenal transit, should be taken ten minutes later—*with the patient upright*; (4) the second picture, to show conditions at the ileo-cecal juncture, should be taken at 3 o'clock in the afternoon—*with the patient prone*; (5) the third picture, to show the condition and position of the colon, should be taken at 9 o'clock the next morning—*with the patient upright*. These pictures are essential; others may be taken or not according to the indications of the individual case.

The ease with which all of this can be done, and the importance of the facts thus elicited, make such examination of these cases an imperative duty not only for individual practitioners but for institutions, hence, (1) All institutions for epileptics should be provided with a well-equipped, competent and liberally supported roentgenologic service. (2) There should be a roentgenologic survey of the entire epileptic population of all public institutions for the purpose of determining the condition of the abdominal viscera. (3) The diagnosis should be individualized in each case with reference, first, to visceral causative factors; and, second, to available treatment with the object and understanding that the treatment in all cases should be directed to overcoming such visceral conditions either by medical and hygienic treatment or, when necessary, by surgical restitution of the parts.

The same rules apply, with possibly greater force, to all hospitals for the insane,—but that is another story.—*Chas. A. L. Reed, paper before Southern Medical Association, 1920.*

**SYPHILITIC CHANCRE OF THE TONSIL IN THE SHAPE OF A POLYPUS.**—Among the numerous cases of chancre on the tonsils that have come under his observation in six months, July to December, 1919, Dr. Geo. Portmann mentions that of a patient who had rather a large polypus growth on his left tonsil on a level with a superficial ulceration of this organ. The two columns and the adjoining part were of a crimson color. To the touch the tonsil was hard except on a level with the polypus growth. Big carotid ganglion on the left, sluggish, moving under the finger, concomitant papulous roseola. Test of Bordet-Wassermann, positive.

This polypus variety of chancre on the tonsil is to be added to different admitted types; erosive, ulcerous, anginal, diphtheritic, gangrenous and epitheliomatous.

With regard to him the writer insists on the encircling of the primary accident, no matter what its shape may be, by the adjoining tissues, which are more or less tumefied but are always of a characteristic crimson color. According to him this special aspect is a symptom of importance, a sign of probability as important as the hardening of the base or adenopathy.

Lastly he draws attention to the facility with which the secondary manifestations are produced on a level with the organ first affected. When the tonsil has been the entry of syphilitic infection, it seems to become the weak point of the organism, the seat of election of the first mucous spots which often appear even when the chancre is not completely cured.—*Paris Médical*.

THE NATIONAL ANESTHESIA RESEARCH SOCIETY has adopted a uniform chart for use in all hospitals. After studying and comparing charts from all leading hospitals and clinics of the United States a committee devised the chart which is considered to embrace all essential points in the administration of an anesthetic and leaves such a record as will speedily show the surgeon, anesthetist and nurse the history of their case.

This chart has been designed to show what happens to the patient and how he reacts to the various factors that bear upon his case. Detailed records of this nature have been all too few. Blood pressure, respiration, the color of the skin and the reaction of the pupil are of prime importance and the requirement of such records will stimulate better work on the part of all. Such records, systematically kept, will yield information never before available to the medical and surgical world. In the interest of such information, the N. A. R. S. will print and distribute at cost this uniform chart to all hospitals using it.—*Bulletin National Anesthesia Research Society*.

SOME RARE LOCALIZATIONS OF MUSCULAR AND ARTICULAR RHEUMATISM.—Having lately observed unusual localizations of rheumatism which could easily give rise to error in diagnosis, Mr. Janowski, physician of the Infant-Jesus Hospital of Varsovia points them out in a practical manner in an article published in the *Paris Medical*, of which we reproduce the most essential phases.

## (A) MUSCULAR RHEUMATISM.

The number of different localizations in muscular rheumatism, according to the author, has considerably increased since the war, which he thinks are due to the prolonged stay in the trenches, to the protracted marches and to traumatism due to heat and mechanical injuries, to which the soldiers were particularly exposed. A special space must first be accorded to the rheumatism of the muscles and tendons of the lower limbs, but these affections are too well known for Mr. Janowski to dwell upon them. He on the contrary, points to a considerable number of Officers whom he has seen suffering with muscular rheumatism of the thoracic region, too often mistaken for pleurisy. He notes, as a differential diagnosis, the absence of frictional sounds, of cough, and the particular sensibility of intercostal muscles, notably in the superior interspaces and at times, an inflammatory oedema of the skin with an acute sensibility at the costal-cartilage junction in the second and third ribs. The author recalls a case of thoracic rheumatism which proved difficult to diagnose, and, here, he remarks that in these cases the muscular sensibility brings about a lessening of the respiratory murmur which, in itself, may lead into error. It is therefore more essential to palpate very carefully the thorax of patients who complain of pain in this region, before attempting the habitual diagnosis of pleurisy or even pneumonia.

## (B) ARTICULAR RHEUMATISM.

Mr. Janowski draws attention to three points of localization: The first is the rheumatism of the sacro-iliac synarthrosis (immovable joint) of which he has observed but two cases in 24 years, but lately, he has seen 8 cases in a few years. The wrong diagnosis of sciatica, or even osteomyelitis of the ilium had, at times, been made, so intense had been the pain. Secondly comes the rheumatism of the intervertebrate articulations. He relates a case involving the four vertebræ of the neck where the pain was so extensive as to point to a basal meningitis, others, localized in the dorsal vertebrae, would simulate Pott's Disease or a luetal infection in these regions, or even cancer of the oesophagus. Thirdly, the author cites the rheumatic inflammation of the costovertebral joints, generally at the level of the four or five lower



ones. There, again, we may think of pleurisy, of pyelitis, even of para nephritis. But the sensibility in that region is increased by the movement of the trunk when the pelvis is at rest, and a careful palpation will localize the maximum painful region to the vertebrae just mentioned. The palpation of adjacent vertebrae may, at times, be also painful. In all of these manifestations rather uncommon in rheumatism, the administration of the salicylates is at times the best means of clearing up a difficult diagnosis.

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Translated from the (*Monde Médical*) by DR. C. M. MENVILLE, Houma, La.

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## NEWS AND COMMENT

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THE ORLEANS PARISH MEDICAL SOCIETY elected the following officers for the year 1921 at the regular annual election held December 11, 1920:

Dr. S. M. Blackshear, president; Dr. W. H. Block, 1st vice-president; Dr. W. H. Harris, 2nd vice-president; Dr. F. R. Gomila, 3rd vice-president; Dr. J. A. Lanford, treasurer; Dr. Elizabeth Bass, secretary; Dr. S. C. Jamison, librarian.

As additional members of the Board of Directors: Dr. E. A. Ficklen, Dr. F. Chalaron, and Dr. F. M. Johns.

Delegates to Louisiana State Medical Society.—(1920-1921) Dr. G. S. Bel, Dr. S. M. Blackshear, Dr. A. Eustis, Dr. W. H. Seemann, Dr. F. M. Johns, Dr. E. L. Leckert, Dr. L. H. Landry, Dr. W. H. Knolle. (1921-1922) Dr. H. W. Kostmayer, Dr. W. W. Leake, Dr. W. D. Phillips, Dr. T. J. Dimitry, Dr. R. Bernhard, Dr. F. Chalaron, Dr. H. E. Bernadas, Dr. H. P. Jones, Dr. E. A. Ficklen, Dr. E. W. Mahler.

THE OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL CLUB OF THE ORLEANS PARISH MEDICAL SOCIETY met at the domicile of the Society on December 8th. The meeting was well attended, including a number of visiting physicians.

A healthy condition of the treasury was shown in that there are funds sufficient to carry on the affairs of the organization without calling for the usual yearly dues. All the old officers were

again elected. Dr. Marcus Feingold, chairman; Dr. Theodore Dimitry, vice-chairman, Dr. Patton, secretary.

Very instructive and interesting cases were presented by Dr. Folsie, who is a member of the intern staff of the Charity Hospital; Dr. A. Weil; Dr. Crebbin; Dr. Whitmire; Dr. Bahn and Dr. Dimitry. The cases presented were much discussed and the evening spent was scientifically pleasing.

RECAPITULATION OF VENEREAL DISEASE CASES.—This recapitulation issued by the Surgeon General of the Army November 23, 1920, supports the averages for 10,000 similar cases of the preceding twelve months showing that the majority of venereal infections (68%) are not contracted in houses of prostitution, that money is not a consideration in the majority of cases (61%); that alcohol was reported as a factor in only 17% of those cases and that communities remote from military stations were sources of infections in 38% of those records.

NON-BEVERAGE ALCOHOL RULE CHANGED.—Administrative officers at the Federal Prohibition Department at Washington advise that all permits to manufacture and use intoxicating liquor for non-beverage purposes should be renewed by filing applications for renewal with state prohibition directors. These permits must be renewed before the end of the year, or they will automatically expire and the Department at Washington frankly states that it will be a physical impossibility to renew thousands of permits during the last month of the year, with its limited force. Under the new rule, issued on October 15, the duration of permits to purchase was cut from 90 to 30 days.

INCREASE IN ANNUAL DUES OF THE AMERICAN MEDICAL ASSOCIATION.—The House of Delegates of the American Medical Association acted on a proposition submitted by the Board of Trustees to increase the annual Fellowship dues, modifying the by-laws so that an increase from \$5.00 to \$6.00 was made, effective for 1921. This increase has been deemed necessary owing to the great advance in the cost of material and labor in the printing trade.

TUBERCULOSIS ASSOCIATION OFFERS PRIZE CUP.—The National

Tuberculosis Association will award an intercity cup to the city enrolling the largest number of knight banners in the modern health crusade in ratio to the school enrollment for 1921. Another silver cup known as the interstate cup is awarded to the state having the largest number of crusaders. This was recently won by Iowa.

NAVAL AWARD TO PRESIDENT OF THE A. M. A.—The Navy Distinguished Service Medal for meritorious service during the war has been awarded to Admiral M. C. Braisted, the Surgeon General of the United States Navy.

SECTION FOR ANESTHETISTS IN THE A. M. A. IN SIGHT.—It is expected that formal action will be taken at the next meeting of the A. M. A. towards recognition of anesthetists by granting them a section in the Association. This recognition has been sought for several years and no better news can come to the first line workers in this specialty than the announcement above, as it will do much to establish the specialty in a professional way.

AUTO DEATHS IN NEW YORK IN 1920.—Motor vehicle accidents in New York City total 517 for the first nine months of the year. Included in the killings for this period were 262 children under 13 years of age. It is becoming a public health question, even from the little available data regarding the number of fatalities in the large cities in the United States, as it appears now that more people are dying from avoidable automobile accidents than public health problems.

CHILDREN IN INDUSTRIES.—The U. S. Department of Labor, Children's Bureau, Washington, D. C., reporting on the action of the permanent committee on standards of physical fitness for children entering upon employment, fixes in a general recommendation a minimum age of 16 years for entrance into industry on the ground that the period of pubescence is not completed until the 16th year. A recommendation is also made that no child should be allowed to go to work until he has had a complete physical examination and has been declared physically fit for the particular occupation which he is about to take up. Importance is laid on the desirability of having all medical men familiarize

themselves with the work of the Children's Bureau. The report of the committee will be sent to interested persons throughout the country for criticism before being printed.

**NEW ADMIRAL OF THE NAVY.**—Rear Admiral Stitt, at present Director of the U. S. Naval Medical School, has been appointed Surgeon General of the Navy to succeed Rear Admiral Braisted who is retiring at his own urgent request. Admiral Stitt has for thirty-one years given service in the Navy and his appointment will have the full support of the medical profession throughout the country.

**U. S. CIVIL SERVICE EXAMINATIONS.**—The U. S. Civil Service Commission announces open competitive examinations for the positions listed below. Vacancies in the Bureau of War Risk Insurance, Washington, D. C., at the salaries indicated, and in positions requiring similar qualifications, at higher or lower salaries, will be filled from the examinations. The entrance salary for some of the positions will depend upon the qualifications of the appointee as shown in the examination. Applications must be filed under Form 1312 with the Civil Service Commission, Washington, D. C. The positions to be filled are as follows: Medical Referee, \$3,600 to \$4,000 a year; Assistant Medical Referee, \$3,000 a year; Chief, Section of Medical Referees, \$4,000 to \$6,000 a year. Applications for the positions of Roentgenologist, Associate, Assistant and Junior Roentgenologist will be received until April 5, 1921. The applications for the other positions must be on file by January 11.

**THE SOUTHERN MEDICAL ASSOCIATION.**—This Association held its annual session in Louisville, Kentucky, from November 15 to 18, with successful outcome. The sections were well attended and interesting and the scientific exhibits were an especial feature. One individual exhibit of unusual merit was that of Dr. Kenneth M. Lynch, of Charleston, which was awarded the first prize. Many other prizes and certificates were awarded. The entertainment feature was well conducted and enjoyable. Dinners at which alumni of various colleges were seated at tables together encouraged a genial spirit of fraternity.



GOVERNMENT NOTES.—During the past year the Medical Department of the Army abandoned 21 of its 30 general hospitals, seven of which were turned over to the U. S. Public Health Service and the others closed.

The Surgeon General's Office from compiled statistics on the cost of venereal diseases in the army shows that during 1919 venereal diseases caused a loss of 1,923,420 days of duty among the troops. Since the estimated cost of such absences is at the rate of \$7 a day, the direct loss to the army from these diseases was \$13,463,940.

Surgeon General Cumming has announced the completion of plans for the treatment of 15,000 tuberculosis patients in the Public Health Service hospitals. A committee of tuberculosis specialists and members of the Public Health Service will visit the special hospitals to study the prevailing conditions with a view to the standardization of the methods of treatment. Surgeon General Ireland has issued orders that the complement fixation test be uniformly employed in the military service for the diagnosis of tuberculosis.

FRENCH NEUROLOGY CONGRESS.—The next congress of alienists and neurologists of French speaking countries will convene at Luxembourg in 1921. The three topics appointed for discussion are the consciousness of the morbid condition in psychopathies; simulation of mental disease and traumatic epilepsy.

HOTEL DIEU APPOINTS STAFF.—By the appointment of a staff of 35 visiting physicians and surgeons, Hotel Dieu, New Orleans, has made an important change in its policy. Dr. Marion Souchon was elected president of the staff, and Dr. H. W. E. Walther, Secretary.

OREGON DEFEATS ANTIVACCINATION BILL.—The referendum abolishing compulsory vaccination which was voted on in Oregon at the recent election was defeated two to one, the vote for the abolition of compulsory vaccination being about 50,000 and the vote against it over 110,000. The campaign against the measure was carried on by a joint committee of physicians and laymen.

INTERNATIONAL TUBERCULOSIS SOCIETY FORMED.—A permanent

international society for the prevention of tuberculosis, composed of representatives of all nations signatory to the League of Nations covenant and of the United States, was formed October 19, at an international antituberculosis conference in Paris. Sir Robert William Philip, Edinburgh, is the president of the Society, the first meeting of which will be held in the fall of 1921 in London.

ELECTRICAL PURIFICATION OF MILK.—According to the *British Medical Journal* the Medical Research Council of England has recently perfected a method of sterilizing milk by passing through it alternating currents of electricity, the milk being kept meanwhile at a temperature of 144 to 150 degrees. At these low temperatures the injurious effects resulting from the sterilization of the milk at higher temperatures are not produced. After electrolization the milk is cooled. Its taste is not changed and treated in this method it can be kept until the fourth day without souring. While all bacteria are not destroyed, the number is reduced to 99.9 per cent, or one in one thousand. The colon and tubercle bacilli are found to be uniformly killed by this electrical treatment. If on further study of this method it is found that the vitamins are not destroyed and no other injurious effect produced upon the milk, its general introduction may become the means of greatly reducing the death-rate among infants and children.

INTERNATIONAL PUBLIC HEALTH JOURNAL.—The first number of the new *International Health Journal* is now out, issued by the General Medical Department of the League of Red Cross Societies at Geneva, Switzerland. This journal will be devoted almost entirely to public health work and preventive medicine and will be published every two months in four languages, French, English, Italian and Spanish. The editor is Dr. T. R. Brown, of Baltimore, and associate editor is Dr. W. F. Francis of Montreal.

ST. LOUIS UNIVERSITY CENTENNIAL.—A Centennial Endowment Fund has been started by the St. Louis University in the hope of raising \$3,000,000 in commemoration of the founding of the institution. The anniversary really occurred in 1918 but on account of the war the celebration was postponed. St. Louis University holds the distinction of having established in the Louisiana Purchase tract the first colleges of medicine, dentistry and law, as well

as commerce. The largest part of the amount raised is to be devoted to medicine and dentistry in the erection of new buildings, clinics and laboratories.

**JEWISH WAR SUFFERERS TO HAVE MEDICAL UNIT OVERSEAS.**—The Joint Distribution Committee of the American Funds for Jewish War Sufferers makes the announcement that a medical unit will be sent overseas next month to fight disease in Eastern Europe. The Medical Advisor of the Committee, Dr. Harry Plotz, of the Mount Sinai Hospital, will be in charge of the work and will head the unit which is to be made up of physicians with military experience. The sum of \$2,000,000 has been asked for as an initial outlay for the first year to cover expenses of payment of medical personnel, purchase of medical supplies, and other necessary items. Dr. Plotz will receive applications for volunteers.

**MORE COFFEE DRUNK SINCE PROHIBITION.**—The Secretary of the National Coffee Roasters' Association is authority for the statement that sixteen billions more cups of coffee have been consumed in 1920 than during the entire year of 1919. The increased consumption is attributed to prohibition.

**THE AMERICAN COLLEGE OF SURGEONS** is organizing state meetings of the Clinical Congress of Surgeons which hold meetings arranged on a plan similar to that of the Clinical Congress. Meetings have already been held in a number of states. The Louisiana branch will hold a meeting on the 10th or 11th of January, 1921. The program will include clinical meetings from 9 A. M. until 1 P. M. Monday and Tuesday, January 10 and 11. At 2.30 P. M. there will be a resumé of the morning clinics and a session on each day, in which distinguished visitors will participate. Monday and Tuesday at 8 P. M., meetings will be held intended especially to interest the public at large. These meetings elsewhere have been well attended and it is hoped that these will be equally so. The meeting will be conducted under the auspices of the fellows of the American College of Surgeons in Louisiana, the invitations to be extended especially to the members of the College in Arkansas and Mississippi, which states, it is expected, will hereafter reciprocate with us. Dr. Gessner is Chairman of the Committee to look after

the clinical portion of the program and it co-operating with the Committee of arrangements, consisting of Drs. Miller, Dupaquier, Kohlman and Oechsner. At the last meeting in Montreal Dr. Dimitry, of New Orleans and Dr. Graves, of Monroe, were elected fellows of the college, and Dr. F. W. Parham was elected member of the Board of Regents.

AT THE ANNUAL MEETING OF ST. TAMMANY PARISH MEDICAL SOCIETY held Dec. 9, 1920, the following officers were elected for 1921: President, Dr. A. G. Maylie; Vice-President, Dr. N. M. Hebert; Secty-Treas., Dr. H. D. Bulloch; Delegate to La. State Medical Society, Dr. J. F. Buquoi; Alternate Delegate, Dr. H. D. Bulloch. The aforementioned are the 1920 officers and were all re-elected. The installation will take place at the annual banquet to be given on January 13, 1921.

NEW HEALTH BOARD APPOINTED.—The following members comprise the new health board for the parish of Orleans: Dr. John T. Callan, superintendent, vice Dr. W. H. Robin, resigned; Dr. E. F. Bacon, chief medical inspector, vice Dr. Paul J. Gelpi, resigned; Dr. P. T. Talbot, medical inspector; Dr. H. G. Patterson, chief food inspector; Dr. J. M. Koelle, inspector; M. J. Lacy, superintendent of the department of promotion and cleanliness; Cassius M. Clay, chemist, vice Dr. A. L. Metz, resigned. The two citizen members of the board are Wm. A. Coker, and George H. Conrad. The superintendent has appointed Dr. E. L. Leckert as secretary-treasurer.

INFANT MORTALITY IN EUROPE.—When the war broke out the movement for the preservation of infant life was progressing rapidly, and it is gratifying to know that even though the progress has been somewhat checked, most of the attained results have been maintained. It is generally believed that tiny babies have suffered most from the war, but this is not so. Children from 2 to 5 years show an increased mortality, although less so than old people, but the breast-fed infants are the least to suffer from the misery of war.

STATE BOARD OF HEALTH OF MINNESOTA NEEDS EPIDEMIOLOGISTS.—A large amount of field work is to be done throughout the state of Minnesota and the Division of Preventable Diseases



of the Minnesota State Board of Health, University Campus, Minneapolis, desires to get in communication with men of suitable training competent for the work which is under way. A salary of \$3000 will be paid, more or less, according to training and experience of applicants. The extent of the field work may be judged from the fact that in 1918 there were 260 and in 1919, 328 field investigators.

**PERSONALS.**—At the Centennial celebration of the College of Medicine of the University of Cincinnati, the degree of Doctor of Science was awarded to Dr. C. C. Bass, Director of the Laboratories of Clinical and Tropical Medicine of Tulane University.

Dr. J. T. O'Ferrall announces the opening of a department of Physiotherapy, (physical education and orthopedic massage), in connection with his office. Mrs. Helen J. Cunningham will be in charge of the department.

Dr. Val H. Fuchs has returned from a two week's visit to the East.

**REMOVALS.**—Dr. Frank R. Gomila has moved to Room 516, Machecha Building, from 504.

Dr. Andrew Conrad Achee has moved from Port Eads, La. to 6024 Camp St., New Orleans.

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## **BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.**

By P. T. TALBOT, M. D., Secy-Treas.

The following is submitted for the information of the Chairman and personnel of each Committee, in order that they may have ample time in which to accomplish something in their respective field, before the Annual Meeting of the Society, April 19th, 20th and 21st, 1921:

### **STANDING COMMITTEES**

*Committee on Scientific Work.*—Dr. P. T. Talbot, chairman; Dr. A. Henriques, New Orleans; Dr. S. M. Blackshear, New Orleans.

*Committee on Public Policy and Legislation.*—Dr. Clarence

Pierson, chairman, Alexandria; Dr. Homer Dupuy, New Orleans; Dr. E. W. Mahler, New Orleans; Dr. P. T. Talbot, New Orleans; Dr. I. Cohn, New Orleans.

*Committee on Publication.*—Dr. P. T. Talbot, chairman, New Orleans; Dr. J. E. Knighton, Shreveport; Dr. Amédée Granger, New Orleans.

*Budget and Finance Committee.*—Dr. H. W. E. Walther, chairman, New Orleans; Dr. E. W. Mahler New Orleans; Dr. T. A. Roy, Mansura; Dr. W. H. Knolle, New Orleans; Dr. E. M. Ellis, Crowley.

*Committee on Medical Education.*—Dr. W. H. Knolle, chairman, New Orleans; Dr. J. E. Knighton, Shreveport; Dr. C. W. Allen, New Orleans.

*Committee on Memorial.*—Dr. W. H. Seeman, chairman, New Orleans; Dr. J. A. O'Hara, New Orleans; Dr. J. N. Thomas, Pineville; Dr. A. E. Fossier, New Orleans; Dr. R. G. Holcombe, Lake Charles.

*Committee on Medical Defense.*—Dr. P. T. Talbot, chairman, New Orleans; Dr. J. C. Willis, Shreveport; Dr. Hy. Leidenheimer, New Orleans.

#### SPECIAL COMMITTEES

*Committee on Public Health.*—Dr. T. A. Roy, chairman, Mansura; Dr. Louis Abramson, Shreveport; Dr. M. W. Swords, New Orleans.

*Committee on Health and Public Instruction.*—Dr. R. B. Wallace, chairman, Alexandria; Dr. R. Bernhârd, New Orleans; Dr. R. O. Simmons, Alexandria; Dr. P. Graffagnino, New Orleans.

*Committee on Cancer Research.*—Dr. W. H. Harris, chairman, New Orleans; Dr. J. C. Willis, Shreveport; Dr. A. Henriques, New Orleans.

*Committee on Hospitals.*—Dr. J. W. Newman, chairman, New Orleans; Dr. C. A. Weis, Baton Rouge; Dr. R. B. Harrison, New Orleans; Dr. L. J. Menville, New Orleans.

*Committee on Hospital Standardization.*—Dr. R. O. Simmons, chairman, Alexandria; Dr. J. C. Willis, Shreveport; Dr. H. W. Kostmayer, New Orleans; Dr. Louis Abramson, Shreveport; Dr. J. A. Estopinal, New Orleans; Dr. C. P. Gray, Monroe; Dr. E. W. Mahler, New Orleans.

*Committee on Industrial and Economic Relations to Medicine.*—

Dr. I. Cohn, chairman, New Orleans; Dr. A. E. Fossier, New Orleans; Dr. W. H. Block, New Orleans; Dr. Geo. F. Roeling, New Orleans.

*Committee on Resolutions.*—Dr. T. A. Roy, chairman, Mansura;

Dr. B. W. Smith, Franklin; Dr. Louis Abramson, Shreveport.

*Committee on Health Problems in Education.*—Dr. A. A. Herold,

chairman, Shreveport; Dr. G. C. Antony, Tioga; Dr. A. L. Whitmire, New Orleans; Dr. H. P. St. Martin, Houma; Dr. S. L. White, Ruston.

*Committee to study Drug Addiction.*—Dr. W. H. Seemann,

chairman, New Orleans; Hr. Hy. Daspit, New Orleans; Dr. R. M. Van Wart, New Orleans; Dr. A. L. Levin, New Orleans; Dr. C. V. Unsworth, New Orleans.

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The Society will expect a report from the Chairman of each Committee, on their respective workings and accomplishments during the year, to be read at the Annual Meeting in New Orleans.

Dues for the year 1921, Louisiana State Medical Society, are now being accepted in the office of the Society, 1551 Canal St., New Orleans, La. If your parish is organized, send your dues in to the Secretary or Treasurer of your Parish Society. If you Parish is *not* organized, kindly make check payable to the Louisiana State Medical Society, in amount \$4.00, and mail direct to the office of the Secretary of the State Society.

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The Annual Meeting of the Society, 1921, promises to be one of unusual benefit and interest to our members.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

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**Principles and Practice of Physical Diagnosis.** By John C. da Costa, Jr., M. D. W. B. Saunders & Co., 1919.

The name, Da Costa, seems properly to fit the title-page of a book on Physical Diagnosis. The subject matter is a family tradition of the author. Everywhere there is evidence of the most complete acquaintance with the literature of the subject. The author mentions by name many of those who have made classic contributions to the subject. However, one is disappointed in a book of six hundred pages designed for undergraduate students and practitioners to find no specific reference bibliography whatever.

Such a tendency in the instruction of students is to be deplored. The student only too often fails to arrive at a realization of the debt he owes to those who have gone before him, in medicine. Surely a book like this one could be expected to contain a bibliography of some sort.

In the chapter on rales and their classification, the author has departed from the excellent and clear anatomic classification of J. M. Da Costa who mentions three categories—(1) Bronchial, (2) Vesicular, (3) Cavity.

The younger Da Costa in this volume endeavors to put forth his own classification of rales, based partly on anatomic and partly on auditory qualities. This mixing of main headings has no justification and serves no purpose excepting to add to the confusion already existing on the subject. In the main, the book is valuable, and the author deserves commendation for having brought the subject matter up to the day.

J. BIRNEY GUTHRIE.

**Mind and its Disorders.** By W. H. Stoddart, M. D., Lond., F. R. C. P. H. K. Lewis & Co., London.

The present work covers 572 pages of text and over 80 illustrations and diagrams.

The book is divided into three sections. In the first, which deals with normal psychology, an attempt is made to correlate mental processes with their physical substrata in the nervous system. In the second section the psychology of the insane is treated in a similar manner. In the third section mental diseases are presented with a classification which though not entirely Kraepelinian is almost as serviceable.

The nervous psychoneurosis, toxic insanities and organic insanities are discussed, fully covering some 22 chapters. Then follows a chapter on idiocy and imbecility with the presentation of Binet-Simon tests and their interpretations.



The author goes more into the details of treatment of mental disorders than will be found in most other works. Each disorder is followed by suggestions for its individual management and treatment and besides there is a chapter on the general treatment of mental disorders.

Space does not permit further mention of the many other good features of this work. Suffice it to say that this book contains more valuable information to the student and practitioner than any other work on the subject.

CAZENAVETTE.

**Surgical Shock and the Shockless Operation through Anoci-Association.**

By George W. Crile, M. D. and William E. Lower, M. D. Edited by Amy F. Rowland, B. S. W. B. Saunders Company, Philadelphia and London, 1920.

This book should need no introduction to the medical profession and those of us who enjoyed and profited by the reading of the first edition will find much additional evidence and argument in support of Dr. Crile's theories.

While some may still dispute these theories they must all admit that no other skilled and trained investigator has given such untiring study and serious consideration to this subject. Added to his vast clinical and laboratory experience we now have his observations and studies made on the battlefield and in the field hospitals of France where a vast number of cases of mutilation in every conceivable form were studied. He was thus able to observe on our wounded fellowman conditions which for humanitarian reasons were never attempted on laboratory animals. "Our researches on animals which have extended through many years, have included experiments covering every cause of shock and exhaustion except those which are impracticable on account of their cruelty. This war, however, has provided ample human material to make good the deficiencies in laboratory researches caused by due consideration for the suffering of animals." The author gives a comprehensive review of the researches on shock, but without reviewing the theories, presenting it in his usual convincing, elegant and fascinating style.

Any surgeon who claims to be competent and well equipped whether he reads Dr. Crile's book or not must consciously or unconsciously adopt the principles laid down by this great surgeon.

CARROLL W. ALLEN.

**The Microbiology and Microanalysis of Foods.** By Albert Schneider, M. D., Ph. D. P. Blakiston's Son & Co., Philadelphia.

This volume contains much valuable information on the various phases of food decomposition, of the organisms concerned in food spoilage, of the foods especially liable to be harmful or dangerous for human consumption, and of the food adulterants.

The text is clear and concise. The book was primarily intended for the use of army dietitians, and food examiners. It is equally as well suited for the needs of students in universities and colleges where special instruction in the analysis of food and drugs, where courses in dietetics, in home economics, in food testing, and in food decomposition are given.

Many excellent plates are found throughout the book showing the

great variety of vegetable cells, vegetable tissues, crystals, yeasts, molds, and bacteria. One chapter is devoted to general and special micro-analytical methods, these include the organoleptic tests, direct microscopical examinations and indirect methods such as plate and tube culture and feeding tests. The ratings of food products are based on years of practical experience by the author and are most instructive. The legal standards of purity are those accepted by the Bureau of Chemistry of the U. S. Department of Agriculture. A diet schedule by Dr. Glen J. Sipes covering analysis of foods in the natural state, and showing the percentage each article contains of heat, strength, nerve, water, and waste products represents the latest conclusions in this line.

ELIZABETH BASS.

**Clinical Microscopy and Chemistry.** By F. A. McJunkin, M. A., M. D. W. B. Saunders Co., Philadelphia and London.

The author presents this small volume in order to bring to the attention of the student the clinical application of chemical and biologic methods and to present them from the laboratory point of view. The contents of the book include study of the blood, sputum, serous fluids and exudates, feces, urine, and gastric contents. One chapter is devoted to hystologic and autopsy technic.

The book is suitable for the physician who has little time for general reading.

ELIZABETH BASS.

**Regional Anesthesia.** By B. Sherwood-Dunn, M. D. F. A. Davis Co., Philadelphia, 1920.

This book is said by its author to summarize the writings of Victor Pauchet, P. Sourdat and J. Labouré as well as himself.

An attempt is made to cover the entire field of local anesthesia, but it is entirely too brief and superficial. Local anesthesia when applied to major surgery must be thorough in all its details to insure success; the technique imperfectly, carelessly or superficially carried out must lead to failure. Any description of this technic should be so ample and thorough that the beginner or student can find in it a reliable and safe guide. If this is not the case, the beginner who often fails of complete surgical anesthesia in his first attempt is unable to figure out where or why he failed.

Local anesthesia must offer to the patient a painless operation and when your technique fails to produce a surgical anesthesia it is the patient who suffers.

Most chapters in the book give the impression that they had not been finished. One who already knows may find the book a convenient guide but the beginner will be hopelessly lost; for instance in hernia the sac is not dealt with at all or any reference made to its sensibility. You are simply directed to inject along cord in the inguinal canal and no directions are given for the handling of the hernial contents. Most subjects are dealt with about as the above and while the experienced operator under local anesthesia may find it a convenient reference book, it will be disappointing to the beginner. Many of the illustrations are

excellent, particularly the anatomical cuts many of which will be found quite useful.

Some suggestions regarding the construction of syringes will be found helpful.

The use of the term mils in speaking of quantity of solution instead of c. c. may be puzzling. While the book has many shortcomings and one typographical error, there are several useful suggestions and much in it that will repay its careful reading by the experienced surgeon.

CARROLL W. ALLEN.

**Medical Record Visiting List.** Wm. Wood & Co., New York.

This visiting list and physician's diary for 1921 is up to its usual standard. Its contents have been revised and modernized which makes the booklet even more desirable than ever.

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## PUBLICATIONS RECEIVED

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**F. A. DAVIS CO.,** Philadelphia.

**Bacteriology for Nurses,** by Henry W. Cary, M. D.

**Practical Massage and Corrective Exercises,** by Hartvig Nissen.

**Refraction and Motility of the Eye,** by Ellice M. Alger, M. D., F. A. C. S.

**Short Talks on Personal and Community Health,** by Louis Lehrfeld, M. D.

**WILLIAM WOOD & CO.,** New York.

**Physiological Chemistry,** Third edition, by Albert Mathews, Ph. D.

**Text-Book of Histology,** Sixth edition revised, by Frederiek R. Bailey, A. M., M. D.

**Steadman's Medical Dictionary,** Sixth edition, by Thomas L. Steadman, A. M., M. D.

**Text-Book of Nervous Diseases,** Ninth edition, by Charles L. Dana, A. M., M. D., LL. D.

**Medical Record Visiting List, 1921.**

**C. V. MOSBY CO.,** St. Louis.

**Physiology and Biochemistry in Modern Medicine,** Third edition, by J. J. R. Macleod, M. B.

**THE MACMILLAN CO.,** New York.

**The Story of the American Red Cross in Italy,** by Charles M. Bakewell.



**W. B. SAUNDERS CO., Philadelphia and London.**

The Medical Clinics of North America, Vol. 4, No. 2, September, 1920.

Manual of Pathology, Fourth edition, by Guthrie McDonnell; M. D.

Basal Metabolic Rate Determination, by Walter M. Boothby, A. M., M. D., and Irene Sandiford, Ph. D.

The Endocrines, by Samuel W. Bandler, A. B., M. D., F. A. C. S.

Chemical Pathology, Fourth edition, by H. Gideon Wells, Ph. D., M. D.

Practical Preventive Medicine, by Mark F. Boyd, M. D., M. S., C. P. H.

Collected Papers of the Mayo Clinic, Vol. XI, 1919.

The Surgical Clinics of Chicago, October, 1920, Vol. 4, No. 3.

**LEA & FEBIGER, Philadelphia and New York.**

Treatment of Gonorrhoea, by Norman Lumb, O. B. E.

Essentials of Histology, by Sir Edward S. Schafer, F. R. S.

Public Health and Hygiene, by William H. Park, M. D.

Syphilis; Diagnosis and Treatment, Second edition, by Lloyd Thompson, Ph. B., M. D.

Surgery; Principles and Practice, Second edition, by Astley P. C. Ashurst, A. B., M. D., F. A. C. S.

Principles of Biochemistry, by T. Brailsford Robertson, Ph. D., D. Sc.

**CLOYD J. HEAD & CO., Chicago.**

Maternitas, by Charles E. Paddock, M. D.

**PAUL B. HOEBER, New York.**

Diathermy in Medical and Surgical Practice, by Claude Saberton, M. D.

Diabetes, by Philip Horowitz, M. D.

Hygiene of Communicable Diseases, by Francis M. Munson, M. D.

**P. BLAKISTON'S SON & CO., Philadelphia.**

Practical Bacteriology, Blood Work and Animal Parasitology, Sixth edition revised and enlarged, by E. R. Stitt, A. B., Ph. G., M. D., Sc. D., LL. D.

**A. F. PATTEE, Mt. Vernon, N. Y.**

Practical Dietetics, by Alida F. Pattee

State Board Requirements in Dietetics and State Board Examination Questions.

**WASHINGTON GOVERNMENT PRINTING OFFICE, Washington, D. C.**

United States Naval Medical Bulletin, Vol. 14, No. 4, October, 1920.

Poison Ivy and Poison Sumac and Their Eradication, by C. V. Grant and A. A. Hansen.

The Control of Communicable Diseases.

Flat Foot and Other Foot Troubles.



**Regulations for the Control of Arsphenamine, Neoursphenamine, and Sodium Arsphenamine in the District of Columbia.**

**U. S. Department of Agriculture, Service and Regulatory Announcements.** Supplement. Notices of Judgment Under the Food and Drugs Act. September 27, October 9, 19 and November 11.

**Public Health Reports,** Volume 35, Nos. 40, 41, 42, 43, 44, 45, 46, 47, 48.

**PANAMA CANAL PRESS,** Mount Hope, C. Z.

**Report of the Health Department of the Panama Canal 1919.**

**MISCELLANEOUS:**

**Is Leprosy Increasing,** by Frederick L. Hoffman, LL. D., F. S. S., F. A. S. A. An address.

**National Health Insurance and the Medical Profession,** by Frederick L. Hoffman, LL. D., F. S. S., F. A. S. A.

**International Health Board,** Sixth Annual Report, January 1, 1919, to December 31, 1919.

**Johns Hopkins Hospital Reports (special volume) Investigation of the Central Nervous System.** The Johns Hopkins Press, Baltimore.

**Quarterly Bulletin Louisiana State Board of Health,** Vol. XI, No. 3., September, 1920.

**REPRINTS.**

**Allergy, Anaphylaxis and Immunity in Hay-Fever and Asthma; Diagnostic Tests in Hay-Fever and Asthma,** by William Scheppegrell, A. M., M. D.

**Report of Committee on Graduate Medical Education,** by Louis B. Wilson, Chairman.

**La Fossette Endolymphatique; Cellulite Mastoïdienne Postérieure Latente; Le Fibro-tuberculome du Larynx; Mastoïdite et mal de Pott sous-occipital,** by G. Portmann, M. D.

**Calomel and Syphilis,** by Ferdinand Herb, M. D.

**Case of Gundiü Observed in Bahia Brazil,** by Drs. Fernando Luz and Octavio Torres.

**A Case Multiple Lesions in Leishmaniosis,** by Octavio Torres, M. D.

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## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the  
City of New Orleans, for November, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever .....	1	2	3
Intermittent Fever (Malarial Cachexia) .....	1		1
Smallpox .....	1	2	3
Measles .....	1		1
Scarlet Fever .....			
Whooping Cough .....	1		1
Diphtheria and Croup .....	2	2	4
Influenza .....			
Cholera Nostras .....			
Pyemia and Septicemia .....	1	1	2
Tuberculosis .....	36	27	63
Cancer .....	28	12	40
Rheumatism and Gout .....		2	2
Diabetes .....	4	1	5
Alcoholism .....	1		1
Encephalitis and Meningitis .....	1	2	3
Locomotor Ataxia .....	4		4
Congestion, Hemorrhage and Softening of Brain .....	25	12	37
Paralysis .....	2	2	4
Convulsions of Infancy .....	2		2
Other Diseases of Infancy .....	14	10	24
Tetanus .....	1		1
Other Nervous Diseases .....	3	2	5
Heart Diseases .....	58	36	94
Bronchitis .....	2	2	4
Pneumonia and Broncho-Pneumonia .....	20	20	40
Other Respiratory Diseases .....	4		4
Ulcer of Stomach .....			
Other Diseases of the Stomach .....	2	1	3
Diarrhea, Dysentery and Enteritis .....	14	7	21
Hernia, Intestinal Obstruction .....	1	2	3
Cirrhosis of Liver .....	5	1	6
Other Diseases of the Liver .....	1	1	2
Simple Peritonitis .....	1		1
Appendicitis .....	6	2	8
Bright's Disease .....	26	8	34
Other Genito-Urinary Diseases .....	16	14	30
Puerperal Diseases .....	3	5	8
Senile Debility .....	1		1
Suicide .....	3		3
Injuries .....	30	17	47
All Other Causes .....	27	17	44
<b>TOTAL</b> .....	<b>349</b>	<b>210</b>	<b>559</b>

Still-born Children—White, 25; colored, 21; total, 46.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 100 per annum for Month—White, 14.44; colored, 22.90; total, 16.77. Non-residents excluded, 14.73.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmosphere pressure..... 30.17  
 Mean temperature ..... 58  
 Total precipitation ..... 3.03 inches  
 Prevailing direction of wind, northeast.

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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EDITOR: CHAS. CHASSAIGNAC, M. D.

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## EDITORIAL

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### TWENTY-FIFTH ANNIVERSARY.

With this issue the writer completes the twenty-fifth year of service on this publication. The loss a few months ago of our esteemed and loved colleague precludes any feeling of elation and almost every expression of satisfaction upon passing this notable milestone of an editorial career. We have missed him and do miss him more than words can tell. Our association in this work was intimate, our collaboration close, and it is partly our conviction that he would want the JOURNAL to continue as before which encourages us to carry on.

Since the time in 1896 that we undertook the editorship and management of this magazine it has never failed to appear on the right day, not once in the three hundred times. During that period we have passed through epidemics, floods, storms, and wars;

yet, invariably, it has been placed in the mail punctually to start its journey to various points not only in this section and this country, but all over the world. It has seen many medical publications come and go, but it has gone unostentatiously yet steadfastly on its way, doing its bit towards the dissemination of medical knowledge and the upholding of professional standards.

And so it shall go on, please God, in the same endeavor to serve the profession to the best of its ability.

We ask the advice and assistance of our friends and readers and shall seek to infuse some new blood in the organization in order all the better to achieve the purpose we have in view.

Already we have solicited the cooperation of the staffs of our local hospitals so as to give to our readers some of the benefit of the scientific work of which they are prolific. In this number we begin the publication of the proceedings of the Medical Staff of Touro. We expect to continue doing so and to see our other hospitals fall in line; in fact we have promises to this effect.

Also in this issue we present an article, somewhat reminiscent in character, from one of our old and able practitioners. We believe it will prove instructive and interesting in many ways and hope to publish from time to time analogous ones from the pen of other "unforgotten worthies."

Other features are contemplated and, if the members of our state and parish societies will remember that this is *their Journal*, so that they will contribute, in addition to their papers, news of interest, abstracts of value, comments on current topics, the NEW ORLEANS MEDICAL & SURGICAL JOURNAL already nearly seventy-seven years old, will continue to live a worth-while life until it is at least over a hundred.

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### ANAPHYLACTIC SHOCK.

On account of the actual vogue of medication by means of various serums, the prevention of anaphylaxis becomes a very important question. Apparently a simple, harmless and practical remedy has been found by means of which this shock may be avoided.

Drs. Lumière and Chevrotier recently presented in a communication to the French Academy of Sciences "a simple means of avoiding anaphylactic shock." Their researches established the



fact that the anaphylactic phenomenon is due to the formation in the blood plasma, at the time of the injection, of a colloidal precipitate which produces asphyxia through obstruction of the capillaries. They next sought for substances capable of preventing the formation of this precipitate and found that the least toxic of these is hyposulphite of sodium. Hence they experimented with the latter on laboratory animals, injecting them with a foreign serum, later repeating the injection with hyposulphite of sodium added to the serum. Such animals never suffered from anaphylactic shock while the control animals, receiving the unmixed serum, invariably succumbed.

If these results are generally confirmed, and we have no doubt they will be, a very important step forward will have been taken and the dread of serum injections will have been removed to a great extent.

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### THE ABDERHALDEN REACTION IN DISREPUTE.

Everyone will recall the furore produced a few years ago by the announcement of a method for diagnosing pregnancy by Abderhalden. This method, to which his name was given forthwith, was said to depend upon the reaction of the body to foreign proteins, leading to their destruction by means of proteolysis.

As so often happens, before an adequate confirmation of the value of the supposed reaction could follow, the overenthusiastic endeavored to extend the field of the test to the diagnosis of cancer and other degenerative diseases. Volumes were written on the subject and right here in New Orleans papers were read before our scientific bodies presenting favorably the claims made for the new reaction.

Doubting Thomases there were and their investigations were given grudging attention until finally, the bold assertion was made that the reaction, which was thought to depend upon the power of the patient's serum to digest specially prepared placental protein, could be produced in the serum of males.

Further investigations, including some by men trained by Abderhalden himself, have failed to support the claims originally made for his method, hence the latter has fallen into disrepute.

The moral is that we should not accept too readily the correct-

ness of theories and methods unsupported by careful and extensive investigation. The point is not less well taken when applied to those "made in Germany."

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### **STANDARDIZATION OF WEIGHTS AND MEASURES.**

There is a world-wide movement in favor of the general adoption of the metric standard of weights and measures. This logical decimal system is already in great favor among the medical authorities and writers of this country who are pretty generally convinced of the advantages of its general adoption in the United States.

We learn that more than 10,000 petitions, representing millions of persons, have been filed with the Department of Commerce at the national capital, urging legislation to establish the general use of the metric system after a liberal period of transition.

Believing that the metric standard is scientific and logical we are in favor of the enactment of progressive laws by the present Congress, establishing such a standard. We would suggest to our readers who favor these views the propriety of communicating them to their respective congressmen.

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### **DRIVE OF SENSES HOSPITAL.**

As we go to press the drive for the benefit of the Building Fund of the Eye, Ear, Nose and Throat Hospital, which we had announced for an earlier date and was postponed, is on. It is not too late for the physicians of the state to rally to the support of this worthy institution. Times are not very propitious, but the hospital has not called upon the public since before the beginning of the war in 1914 and the money is badly needed. Let us all help.

## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### TAPPING OF THE HEART.

By Y. R. LE MONNIER, M. D., New Orleans.

I beg to report the following case of supra acute pericarditis, with tapping of the heart, i. e., not dying, but immediately followed with an organic affection of the heart. The case occurred on Feb. 9, 1875, and as I have not seen another such case since, I conclude that these cases, immediately accompanied with or followed by valvular troubles, dropsies, embolisms, paralysis, etc. are fortunately rare. I have seen other cases of pericarditis, as all of us have, but of an entirely different type, two in particular, with negroes, where it took the autopsy to verify the diagnosis.

**Case.** Mrs. D. 44 yrs. suffered from a light attack of rheumatism in the right ankle; so light was the case that I paid but one visit, cautioning her however against the danger of heart troubles complicating rheumatism. An examination of her heart showed no abnormality then, though, at times, I thought I heard a very faint sound that might not be normal, but as she reported that father, her previous physician, then dead 5 yrs., had said the same thing and no unfavorable symptom had developed, I concluded I was mistaken. She reported that since her 12th year she had been, now and then, subjected to attacks of articular rheumatism.

On the 9th, four or five days later, at 5:30 P. M., I saw her at the request of her husband: I had seen her in the morning, but nothing unusual, except constipation, for which I had prescribed Epsom Salts, that had not been yet taken. A very light dyspnea of the morning had slightly increased, which she reported usual and not worth the trouble of auscultating her chest, and expressed the intention of going to work in the morning.

At 8:30 P. M. her husband called at my office, greatly excited, crying, saying his wife was dying. My house was 1300 feet from his. I hurried there with him. Great was my astonishment to find her, who three hours previous was walking about the room talking and laughing, in bed, dorsal decubitus, face cyanosed, pulse 160, scarcely perceptible to the touch, hair disheveled, panting for breath, body covered with a cold clammy sweat, extremities cold.

Auscultation revealed a pericarditis with effusion, respiratory murmur heard all over the chest except at the cardia, where a very loud

flipflop noise plainly proved the effusion in the pericardium. So loud was this noise that the ladies in attendance exclaimed, "there is water in there." It was distinctly heard at three feet from the bed. No time was to be lost, tapping the only recourse. Young physicians cannot be too careful how they act, and as the chances were 10 to 1 that she would die, I went for an assistant and my aspirator, and returned at 10 o'clock with old Dr. Alpuente, one of the best diagnosticians of our profession who, on one occasion, at the Charity Hospital, with 31 M. Ds., including Prof. Bemiss, as his opponents, proved the correctness of his diagnosis in a case of cancer of the liver. No time to be lost, she is pulseless, said he.

*Operation.* At the 5th intercostal space, below the mamma, half an inch to the left of the sternum, was the spot where the apex of the heart beat and where the flopping noise was the loudest and most distinctly heard. Here I plunged my needle and waited one minute, watch in hand, to see the progress of the disease and approaching death, in the last hour and a half: six (6) pulsations to the minute. A black bloody fluid poured from the needle; I connected the aspirator to the needle and had drawn only one ounce of this fluid when the Madam opened her mouth and with a tremulous voice said, "O Lord! what a relief," Dr. Alpuente, at the same time saying, "stop, the pulse has returned."

After the operation the flip-flop sound disappeared being replaced by a very distinct "*bruit de cuir neuf*" and a rasping sound. In an hour the cyanosis of the face and the dyspnea had disappeared and the temperature of the body was returning.

*Treatment.* Blister, 4 x 5 inches over heart. ℞ Tinct. Digitalis  $\bar{3}i$ , Tinct. Valerian, Tinct. Castorium each  $\bar{3}ii$  M. 15 drops every 2 hrs. Warm water to extremities. Next morning the 10th at 7:30, face pale; pulse returned to 160, scarcely perceptible; blister, unsatisfactory, is sprinkled with fresh tincture of cantharides; renal functions scanty; only a small operation from bowels. 2 P. M., better, blister has acted well, uneasiness and pain at cardiac region, pulse 160. Ordered Norwood's Tinct. Veratrum Viride, 5 drops now and 5 at six o'clock. 6 P. M., better, pulse 144, temperature of extremities still low. Ordered 10 drops Tinct. V. V. now, with 8 of laudanum, on account of nausea; same at 12 P. M. and ditto at 6 A. M. Feb. 11, 9 A. M., much better with pulse at 48, temperature of extremities O. K. has taken 40 drops Tinct. V. V. Stop all medicine, give nourishment.

From this out, she continued improving, going out for a walk



on the 21st; a rapid recovery, another credit to the favorable climate of Louisiana.

Shortly after this, Dr. Flint, of Philadelphia, reported that he had gathered statistics on tapping of the heart and found only four cases with recovery, in the U. S.

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## CONGENITAL MALFORMATIONS OF THE ANUS AND RECTUM, WITH REPORT OF CASES.\*

By ERASMUS D. FENNER, M. D.

**Case 1.** During the summer of 1919 I was called to see, in consultation, a new-born baby who had had no movement of the bowels since its birth three days before. The child was small and emaciated, and evidently desperately ill. The abdomen was distended, and there had been continual vomiting and violent straining ever since birth. Nothing had passed per anum. The anus was well formed, and a catheter passed a couple of inches, but met with an obstruction at this point which I was unable to overcome. It must be admitted, however, that the only catheter available was very soft. A diagnosis of malformation of the rectum was made, and the infant was at once sent to the Charity Hospital in the hope that an operation might save its life. At the hospital it was found that a catheter passed easily up the rectum for eight or ten inches, but irrigating fluid returned untinted by meconium. The child had been sinking rapidly, and was practically in extremis, so that no further interference seemed justified. Within a few hours the baby died, and permission to hold a post-mortem was granted. The autopsy revealed a very remarkable malformation, not of the rectum but of the small intestines. The rectum and colon were normal, but in three different places the small intestine exhibited a gap, the free ends of the loop where the hiatus occurred appearing as blind pouches swinging from the mesentery.

It is evident that so remarkable a malformation could not have been recognized unless an abdominal section had been made, and the entire length of the intestine examined. Moreover the extreme prostration of the baby would have rendered an attempt to do a triple end-to-end anastomosis entirely hopeless. The wisdom of the hospital surgeon in declining to operate was therefore completely vindicated by the autopsy findings.

**Case 2.** On September 13, 1920, I was called, by my friend Dr. Charbonnet, to see another baby who was forty-eight hours old. The condition was one of imperforate anus, with a fistulous communication between the rectum and the urinary tract. A tentative effort to open the rectal pouch through the perineum had been made, but had been abandoned.

The infant was a well nourished, full term, male. He was crying constantly, had some fever, and was straining violently, with the result that small quantities of meconium were forced out through the urethral

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\* Read before the Orleans Parish Medical Society, December 20, 1920.

meatus. Vomiting had been repeated, but was not stercoraceous. The child was evidently in great pain, and the abdomen was considerably distended. No appearance of an anus was to be seen. It was impossible to determine whether the fistulous communication between the bowel and the urinary tract was vesical or urethral. The absence of any sign of ascending infection, or bladder irritation later on inclined me to think it was urethral.

After fully explaining the danger of operation, and the generally bad prognosis of cases of this character, I agreed to undertake a Colostomy to relieve the immediate emergency. To this the parents gave their consent, and I immediately transferred the baby to the Presbyterian Hospital, where under ether a left inguinal colostomy was done. The muscle splitting incision was employed, and upon opening the abdomen numerous coils of small intestines, entirely empty and collapsed, were encountered. A little manipulation soon brought into view the Sigmoid Flexure, distended and black from the contained meconium. This was seized with a pair of placenta forceps, and drawn out of the abdomen, in the course of which manipulation the happy condition of a short mesentery was found to exist. The loop was secured all round to the peritoneum and muscles by fine silk sutures, after which a free longitudinal incision in the bowel permitted the escape of large quantities of meconium. A large sterile dressing was applied, and the patient sent to bed. During the night the baby cried a great deal, chiefly from hunger, I am convinced, although Ducro's Elixir in water was given. Next morning the child was sent home to the mother, and immediately put to the breast, which it took eagerly. There was no vomiting; the temperature became normal; he nursed regularly every two hours; the colostomy wound discharged freely, and gave no trouble of any kind. On Sept. 17 I turned the child over to the care of its mother, and did not see it again until October 11, when it was brought to my office on account of a very tight and adherent prepuce. The child appeared in perfect health, and no one would have suspected from its expression or from the account given by its mother of its peaceful sleep and perfect contentment, that any anomaly existed. Inspection of the abdomen revealed the presence of a small red tumor marking the location of the artificial anus. The prepuce was freed of its adhesions, and the constriction relieved by splitting it up on the dorsum. This small wound healed in a day or two, and the little one was again turned over to its mother's care. From the day the colostomy was done all traces of fecal contamination of the urine disappeared.

**Case 3.** In the beginning of Nov., 1920, a female infant about one month old was admitted to my service at the Charity Hospital on account of an ano-rectal malformation. The infant was plump and in excellent health. It was breast fed, and exhibited no symptoms of fecal obstruction. Examination revealed an imperforate anus, but just back of the posterior vaginal commissure a fistulous opening on the perineum permitted the free escape of feces. Palpation and skiagraphs of the bowel indicated that the termination of the rectal pouch was high in the pelvis, but the fistulous tract was wide enough to permit easy evacuation of the bowel. In view of this condition no attempt at operative interference was advised, and the child was permitted to go to its home.

These striking cases of congenital malformation of the bowel awakened my interest in this subject, and led me to refresh and review my knowledge, of these forms of congenital defect. The other type, congenital interruption of the continuity of the bowel, I shall not attempt to discuss.

Malformations of the Anus and Rectum, with complete or partial obstruction of the fecal discharge, are neither so rare as to be considered curiosities, nor so frequent as to fall within the experience of the average physician. They are said to occur once in 10,000 births. No great predominance is seen in either sex, although the experience of most observers indicates a slight excess of females. Not infrequently, but by no means always, the condition is associated with other congenital anomalies. The embryological relations of ano-rectal malformations will not be entered upon in this paper.

In his work upon Diseases of the Rectum, Cooke says: "From the standpoint of embryology there are many divisions of ano-rectal malformations; surgically they may be grouped into two classes: imperforate rectum terminating at a variable distance from the perineum, with or without an opening into another viscus; secondly, imperforate anus, with or without abnormal outlet in the perineum, vulva, scrotum, or under surface of the penis. The anus may be absent, or developed completely or partially."

By the majority of writers ano-rectal malformations are more definitely divided into the following types, a classification proposed by Bodenhamer, in 1860, and in the words of that author "if not perfect, at least sufficiently plain, comprehensive, and correct for all practical purposes."

Slightly modified in wording, it is as follows: I. Preternatural narrowing of the anus or rectum, without complete occlusion. II. Complete occlusion of the anus by a simple membranous diaphragm, or by integument. III. The anus is absent, and the rectum ends in a cul-de-sac a greater or less distance above its natural outlet, without any communication whatever, externally or internally. IV. The anus is normal externally, but ends in a cul-de-sac; and the rectum ends in a blind pouch at a greater or less distance above, the two being separated by a septum. V. The anus is absent. The rectum is prolonged in the form of a fistulous sinus, and terminates by an abnormal anus at the glans penis, the labia pudenda, or at any point about the perineum or sacrum.



VI. The anus is absent. The rectum terminates in the bladder, urethra, or vagina; or in a cloaca in the perineum with the urethra and vagina. VII. The anus and rectum are normal, but the ureters, the vagina, or the uterus open into the rectal cavity. VIII. The rectum is entirely absent. IX. The rectum and colon are both absent, and there is usually an abnormal anus situated in some extraordinary part of the body.

Obviously the prognosis of these cases is hopeless, unless a means of escape for the intestinal contents either exists, in the form of a fistulous opening sufficiently patent to permit the bowel to discharge itself, or can be created by operative means. Even in cases successfully operated upon, it must be borne in mind that the vitality of these infants is usually low, and that their chance of surviving infancy are not as a rule good. They should therefore always be regarded as grave surgical risks, and not only should this be fully explained to the parents, but the probability of permanent fecal incontinence with its distressing conditions, should be made plain to them. The grave immediate and remote dangers being fully understood, operative interference is justified.

In reviewing the literature on the surgical treatment of these cases, a wide divergence of opinion is encountered and it has seemed to me that the majority which favors the perineal incision in practically all cases, and reserves Colostomy for cases in which the attempt to find the bowel through the perineum has failed, is more academic than practical, and is not sound teaching except in the simpler cases. It is probable that the very favorable mortality statistics of the perineal operation, as compared to the results from inguinal colostomy, are largely due to the inclusion in these tables of numerous cases in which the separation between the perineal surface and the rectal pouch was membranous, or in which the pouch was very near the surface.

Our attitude towards these cases must depend upon the severity and completeness of the malformation. To refuse to operate, and consign the child to a certain and miserable death, on the ground that life is not worth living in the face of a permanent incontinence of feces is, I believe, utterly indefensible. It is the duty of the surgeon to preserve life whenever it is possible, and leave to a higher power the settlement of whether or not life is worth while. Moreover cases have survived till adult life, with little discomfort



or unhappiness. We may lay down the principle, therefore, that operation is indicated wherever there is a chance of averting death even for a short time. Immediate operation is not, however, demanded in all cases. In cases presenting a fistulous opening through which the bowel can empty itself operation may be delayed, or the fistulous tract may be dilated so as to give a better exit to the feces, and the effort to correct the malformation postponed until a more favorable time when the child is older and its powers of resistance better developed. Vaginal, vulvar, and perineal fistulous cases fall under this head. Cases with fistulous communication with the urinary tract demand operation not only because the escape of the feces is apt to be insufficient to give relief to the intestines, but because of the danger of ascending infection of the urinary passages and kidneys. All of these, and all cases in which there is no fistulous exit demand operation at the earliest possible moment. The longer the delay the greater the prostration, the toxemia, and the distension of the abdomen, and the smaller the chance of saving the child.

There are two methods of relieving the fecal obstruction: Incision and opening of the rectum through the perineum, either by simple incision or by proctoplasty; and colostomy, either inguinal or lumbar. Naturally the ideal operation would seem to be one which would create an anal opening in its normal situation, and the majority of writers advise this as the method of choice. Since the publications of Amussat, in 1835, proctoplasty has been the choice of many writers. The perineum is incised in the median line, and if it seems desirable the coccyx, and even the lower segment of the sacrum is split with scissors, so as to give a better field, and search is made for the rectal pouch, keeping as close to the sacrum as possible so as to avoid opening the peritoneum which does not descend as low posteriorly as in front. If the pouch is found, the bowel is freed as much as possible, grasped with forceps and dragged down as near the surface as it can be brought. It is secured by suture, and then opened to permit the escape of its contents. The mucous membrane is then securely sutured to the skin all around, and as far back towards the sacrum as it can be fixed. This tends to increase the chances of sphincteric control, which may be further improved by rotating, or twisting the gut before it is sutured in place.

The difficulties and dangers of this operation in the new-born are obvious. In cases where the rectal pouch is almost at the surface it may be easy enough, but there is no way of determining how high in the pelvis the pouch is located, and deep dissection is attended by many difficulties. One has only to recall the pelvic dimensions in the new-born to appreciate how contracted is the field of operation, and how difficult it may prove to avoid injury of the bladder, or opening of the peritoneum, and how often it will prove impossible to locate the bowel at all owing to its distance from the surface. The pelvic diameters are said to be as follows:

Distance between Ischial Tuberosities is  $\frac{3}{4}$  to 1 inch; from Scrotal or vulvar commissure to tip of coccyx is  $1\frac{1}{2}$  to  $1\frac{3}{4}$  inches. Distance from tip of coccyx to sacral promontory is  $2\frac{3}{8}$  inches. The mechanical difficulties of work in as narrow an operative funnel as this are sufficiently plain, and it is not surprising that many failures to bring down the bowel should occur.

Far less formidable from an operative point of view is the operation of Colostomy in the inguinal region. If the infant survives it has the great disadvantage that the artificial anus is not in the natural place, and that fecal discharge upon the abdomen is a terrible condition to face. Its mortality should, however, be much lower than that of proctoplasty, if we exclude from the statistics of the latter those simple cases in which the obstruction is membranous, and it has the advantage that an effort to restore the normal opening can be undertaken when the child is older and the operative conditions more favorable.

All writers agree that in case of failure to find the bowel by the perineal approach, colostomy must be done, but few have come out boldly in defense of this as the immediate operation of choice. Amongst these is Robert Abbe, in Keen's System of Surgery, who says: "Incidentally the surgeon may well keep in view, and tell the parents, that most children with congenital defects have a naturally deficient vitality during their infancy. Hence any attempt to perfect the restoration of the parts will be a menace to the infant until some years have gone by. For this reason it is generally wise to look upon all cases of rectal defects as bad risks in surgery, and simply offer a well made artificial anus in the left inguinal region as, *ab initio*, the surgical procedure of choice." Jerome M. Lynch, in Vol. 4 of Operative Therapeutics, edited by

Alexander Johnson, takes a like conservative view, or what seems to me to be a wise conservative view. He says: "If there is an outlet, even though it be through some other organ, or at a point distant from the anus, it is better to wait until the child is older than to resort to surgery, provided the life of the child is not threatened by the bowel opening into some vital organ, such as the bladder, a condition which would undoubtedly result in the death of the child from an ascending infection. If such a condition exists, colostomy is indicated, and this can usually be done under local anesthesia.

If the anus is well formed, and only separated from the hind-gut by thin membrane, the membrane can readily be broken down and connection be established between the rectum and anus. If there is some doubt as to the distance between the anus and the hind-gut, as occasionally happens, it is very much safer to make an artificial anus rather than perform an extensive operation with the object of locating the hind-gut and bringing it down to the anus."

In doing a colostomy it is, of course, desirable to bring out a loop of the Sigmoid if it can be located, but often one must be content to secure and open whatever portion of the large bowel can be gotten hold of. Murphy's dictum "to get in quick, and get out quicker" is never more urgent than in these cases, which are often greatly prostrated and unable to withstand any prolonged operation. To waste time in the effort to find the very loop one would like to fix in the abdominal wound is certainly not good surgery. If the sigmoid can be gotten, and particularly if that portion has a short mesentery, all the better, because a short mesentery reduces the chances of prolapse of the bowel should the child survive.

In cases having a fistulous communication with the bladder or urethra, Colostomy diverts the passage of feces from the urinary tract, and it is possible that with the lapse of time the fistula may become occluded, it being well known that such tracts have a tendency to become obliterated if their function is terminated by completely diverting the fecal stream.

The subsequent management of these cases will depend upon many circumstances. Should the parents wish it, an attempt to construct a perineal opening, and to close the inguinal anus, may be made at any time, and certainly the conditions for operation ought to be more favorable than in an infant only a few hours



old. On the other hand, the case may be left to go along without disturbing the status created by the colostomy. Admitting that complete or partial incontinence of feces is a deplorable affliction, I have not been able to convince myself that involuntary discharge of feces between the legs was a very much happier condition of affairs than its escape in the inguinal region. It is true that perineal proctoplasty sometimes gives fairly good sphincteric action, but it is also true that patients have been known to acquire fairly good control of the fecal movements through a colostomy opening. For this reason the superiority of proctoplasty appears to me more academic than real, and whatever may be its theoretical advantages, they are counterbalanced by greater difficulty and greater danger of the operation, except in those very favorable and simple cases in which the rectal ampulla is very close to the surface of the perineum.

The opinions expressed above are at variance with those enunciated by a good many authorities, such as Burghardt and Cheyne who, after urging proctoplasty in all cases calling for operation at all, conclude by saying "When diligent search shows that the rectum is not present in the pelvis, and especially when the peritoneal reflection has been opened and still the end of the gut cannot be found, there is no alternative but to perform colostomy if the child's life is to be saved. This is a most serious procedure and, quite apart from the grave risks pertaining to it in a new-born infant, it is a terrible calamity to inflict on the child, and many parents will decline to permit it when the situation is explained to them as fully as it ought to be." These authors further advise that in cases which have a fistulous communication with the bladder or the urethra colostomy should be done, and the bowel cut clear across. The proximal end should be sutured into the wound, while the distal end is invaginated and tightly closed so as to prevent any passage of feces to the bladder. These recommendations to choose proctoplasty—the more difficult and tedious procedure—in every case, and to have recourse to colostomy only after persistent search has failed to locate the rectal pouch, are prefaced by the statement that "In the first place the child is only a few hours old, and cannot stand prolonged or extensive operation." The attitude these able surgeons take towards Anorectal malformations appears to me entirely at variance with the generally sound and eminently practical teachings which are characteristic of their splendid work on "Surgical Treatment."



**VERTIGO OR DIZZINESS.\***

By DR. S. C. JAMISON

Vertigo is one of the commonest symptoms met with in the practice of medicine. It is always a symptom, never a sign, though it is true that staggering and falling sometimes accompany this symptom.

In a recent series of medical cases, I have found that over 12% of the patients complain of this symptom. It is not always the most prominent complaint, though it frequently occupies the first place. It is never painful, but always disagreeable, and frequently so distressing as to be the main cause for the consultation of the physician.

Vertigo is a disturbance of the sense of equilibrium. Our sense of equilibrium depends on muscular co-ordination and is controlled by the cerebellum. Afferent impulses are conveyed from the muscles, the skin, the joints, the eyes, and the semi-circular canal, and are there regulated.

Two types of vertigo occur: Objective, in which motionless objects appear to move about the patient, and subjective, in which the patient seems to move.

We can divide this symptom into two great groups, the physiological and the pathological. Physiological vertigo is an incorrect term, inasmuch as the normal person, in a purely normal environment, will never suffer from vertigo. In the more restricted sense, however, that a person may have abnormal sensations but remain normal, it is correct. For instance: We have all experienced the sensation of vertigo after having been in a stooping position and having suddenly taken the upright position; we have all had the sensation of vertigo, when on the edge of a precipice, or after swinging, or after rapid rotation. Syringing of the external ear will cause vertigo in the normal person.

From this brief review then, certain aspects of vertigo and the abnormal mechanism producing it, become apparent. The vertigo resulting from the stooping position is due probably to the altered blood supply to the center. The vertigo resulting from standing on the edge of a precipice is ocular and due to the fact that the eye is suddenly deprived of fixed objects by which the posture of the

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body can be regulated. The vertigo resulting from rotation is due to disturbance of the endolymph of the semi-circular canal.

There are five divisions to pathological vertigo: (1) Aural. (2) Ocular. (3) Cerebral. (4) Vascular. (5) Toxic.

The most typical example of aural vertigo is Meniere's Disease, in which there is tinnitus, dizziness, deafness, nausea, and frequently falling to the ground. This is a rare condition, and the usual type of aural vertigo that we see is not at all so characteristic.

If falling accompanies aural vertigo, due to disease of the external semi-circular canals, the patient falls to the affected side and the objects move in a horizontal plane. If the superior canals are affected, objects move in a vertical plane, and the patient falls forward.

It is to be borne in mind that in aural vertigo the deafness is only casually related to the vertigo, and that equilibration and hearing are distinctly separate, although anatomically placed close together. For clinical purposes, however, when vertigo accompanies any disease of the ear, the advice of a specialist should be sought to exclude disease of the semi-circular canals.

Ocular vertigo is due to the faulty localization of objects resulting from diplopia, or from paralysis of the eye muscles. If only one eye is at fault, this vertigo can be caused to disappear at once by the application of a bandage to the affected eye. Needless to say, when cases of vertigo present themselves where there is any reason to suspect disease of the eye, the advice then of an oculist is necessary. These two types of vertigo are due to abnormal afferent impulses.

Cerebral vertigo: The most common type of cerebral vertigo is that depending upon tumors of the cerebellum. It is generally believed that circus or rotary movements are the result of tumors of the cerebellum and that the movements are towards the diseased lobe. In these cases, staggering is a marked sign accompanying the symptom of vertigo.

Increased intra-cranial pressure results in vertigo from direct pressure upon the cerebellum.

In multiple sclerosis, vertigo is present in 75% of cases and is more constantly present than is the case in any known disease.

Syphilitic cerebritis is practically always accompanied by dizziness, and a known syphilitic who complains of this symptom, should

immediately be suspected of involvement of the central nervous system.

The vertigo accompanying migraine should probably be classified as cerebral in type, as well as that vertigo which appears as the aura of an epileptic attack.

Vertigo due to vascular disease results from an abnormal blood supply to the center. This abnormal blood supply may be brought about by arteriosclerosis, by hypertension, by hypotension, or by anaemia. I have yet to meet a case of arteriosclerosis in which vertigo was not a prominent symptom, and in the hypertension of nephritis, its occurrence is notorious. It would appear that merely hypertension, without accompanying arteriosclerosis or nephritis, almost constantly causes vertigo of a pronounced type.

Such diseases as Addison's Disease and Graves' Disease both of which produce hypotension, are also accompanied by vertigo. Any type of anaemia brings about a more or less lasting dizziness.

Where the vascular system is at a fault in the production of vertigo, it has been my experience that the vertigo is of an objective type.

Toxic vertigo is exemplified by the dizziness resulting from alcohol, ether and tobacco, and is of a mixed type—both objective and subjective.

We must regard the dizziness of gastro-intestinal disturbances as toxic vertigo, and I feel fully justified in stating that there is unquestionably a gastrogenous vertigo and a gastro-intestinal vertigo. Such cases are found in heavy eaters, especially of protein food, with a tendency to obesity and constipation. This I consider the most common form of vertigo with which the medical man is confronted, with the exception of the vertigo of arteriosclerosis.

Vertigo often accompanies nephritis, and I believe is usually toxic, although vascular disturbances are so common in nephritis that it is extremely difficult to definitely decide between the two.

Two troublesome, though not serious forms of toxic vertigo, are found in the pregnant woman and the woman at the menopause. It is my opinion that the vertigo seen in neurasthenics belongs in the group of toxic vertigo, but, of course, is primarily dependent upon the underlying cause of the primary psychosis.

Constant vertigo is to be regarded as an extremely serious symptom, and points toward a cerebral lesion, and any vertigo which



persists in spite of the recumbent position is also to be regarded as of an extremely serious nature.

Objective vertigo is much more common than subjective vertigo, though mixed types of vertigo are frequent. It must always be borne in mind that patients describe as vertigo such sensations as fullness in the head, spots before the eyes, ringing in the ears, etc., none of which bear the same significance as vertigo.

In diseases such as tabes, where vertigo is only present when ocular impressions are cut off, or when there is irritation of the afferent fibres of the labyrinthine portion of the eighth nerve, it is extremely difficult to say whether the patient's sense of vertigo is due to the lack of skin and muscle sensation, or comes about only after he begins to fall. It is undoubted that here, however, the lack of afferent impulses from skin and muscle are counterbalanced and controlled by afferent ocular impulses.

In conclusion, I wish to say that I have found that a close study of dizziness, an endeavor to discover its origin, will frequently lead us to important, and perhaps paramount, discoveries regarding the underlying pathology affecting our patient.

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### OCCIPITO-POSTERIOR POSITIONS.\*

By E. L. KING, A. B., M. D., New Orleans.

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Dr. H. E. Miller read a most interesting paper on this subject before the Society several months ago, but I feel that it is so important that a little repetition will not be out of place. Occipito-posterior positions are by no means uncommon, and are frequently not diagnosed as such because, in the majority of cases (90 to 95%, according to Polak), spontaneous anterior rotation takes place and delivery occurs without difficulty. We can be sure that practically all our cases delivered as R. O. A.'s (and a few delivered as L. O. A.'s) were originally posterior positions. But it occasionally happens that the occiput remains posterior, with the sagittal suture in the oblique diameter (usually the right), or rotates slightly anterior and then stops with the sagittal suture in the transverse diameter; "deep transverse arrest." The head is usually

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deflexed to a greater or less extent. Exceptionally, the occiput rotates posteriorly, into the hollow of the sacrum, with the sagittal suture lying antero-posteriorly, and the face looking toward the symphysis. The majority (30 out of 35, according to Varnier) of these occipito-sacral positions deliver spontaneously, but in many of the oblique and transverse positions just mentioned some form of artificial delivery is necessary, and the fetal mortality is high if this is not properly done.

It is not always easy to ascertain just why the head fails to rotate anteriorly in a given case. Imperfect flexion seems to be one of the main factors concerned, coupled with some other condition interfering with the usual mechanism. The following etiological factors are mentioned by various authorities: 1 moderately flat pelvis; 2 funnel pelvis; 3 generally contracted pelvis and certain other pelvic deformities; 4 pendulous abdomen; 5 primary brachycephalia; 6 large pelvis with small child; 7 prolapsed arm in front of occiput; 8 tumors, etc., mechanically preventing anterior rotation; 9 abnormalities of the pelvis floor; 10 exhaustion of uterine muscle before anterior rotation is completed.

Diagnosis—Premature rupture of the membranes is common in all occipito-posterior positions, and should always arouse our suspicions. Frequent and very strong uterine contractions without progress are the rule when anterior rotation fails to occur, or is abnormally slow after being initiated. This condition, of course, would be encountered in other cases of disproportion or malengagement. Labor is prolonged and exhaustion is frequent. On abdominal examination, the back is felt more or less posteriorly (usually to the right), and the small parts to the opposite side and anteriorly. The cephalic prominence is marked, and there is often a hollow above the symphysis, especially in thin patients. The heart sounds are as a rule posterior, generally, of course, on the right side; it may occasionally be impossible to find them. Occasionally, the chest is forced against the uterine wall on account of the deflexion, and the heart is heard anteriorly on the side corresponding to the chest, thus leading us into error. But we can safely consider practically all cases with the heart sounds on the right as posterior. On vaginal examination the small fontanelle is found to be posterior, near the sacro-iliac synchondrosis (generally, of course, to the right). The large fontanelle is an-

terior, and opposite the small. The sagittal suture can usually be felt connecting the two, and is generally lying in the right oblique diameter. On account of the moulding, the small fontanelle (and often even the large one) can not as a rule be felt as such, but by palpating *past* the point where the sagittal and coronal sutures meet we find the occipital bone, which has no suture dividing it. The frontal bone is of course divided into two parts by the frontal suture, and can thus easily be distinguished from the occipital. Hence, even though we can not feel the large fontanelle on account of its inaccessibility, and cannot feel the small fontanelle as such on account of the moulding, we can practically always make the diagnosis by ascertaining what bone (occipital or frontal) is at the posterior end of the sagittal suture, near the sacro-iliac synchondrosis. If we can reach an ear, and note the direction in which it points, the matter is settled. This, however, generally requires an anesthetic.

Prognosis—De Lee states that, in his opinion, at least ten times as many babies are lost from occipito-posterior positions as from the effects of contracted pelvis. Polak gives the fetal mortality as 15%. Williams, on the other hand, states that in the obstetrical service of the Johns Hopkins Hospital the fetal mortality is not greatly increased in this class of cases, and that in private work he lost only one baby in 111 cases. The mortality, of course, is higher when the diagnosis is made late, and treatment delayed. The maternal morbidity and mortality are higher, on account of exhaustion from prolonged labor, sepsis, operative intervention, and lacerations, and the slightly increased liability to postpartum hemorrhage.

The treatment may be considered under three heads; (a) above the brim; (b) in the pelvic cavity; (c) at the outlet. In the first group, "watchful waiting" is best, at least until we are very sure that temporizing is doing more harm than good in this particular case. As soon as the diagnosis is made and labor is well established, the patient should be turned on the side to which the occiput points, and kept in this position for a variable length of time; ten to thirty minutes will often suffice for a multipara, while it may be necessary to keep a primipara in this posture for the greater part of several hours. By this posture, according to De Lee: "The breech is thrown to the side, the spinal column is straightened, the

occiput is forced down, flexion is increased, and therefore, rotation is favored." Rupture of the membranes should be avoided as long as possible. If no rotation occurs, the position can sometimes be changed to an anterior one by combined external and internal manipulation. If dilatation is slow, it may be hastened by a bag. Williams suggests version if there is no progress. De Lee advises against it in primiparæ. When the head has entered the pelvic cavity, rotation may be secured by the use of posture as above mentioned, by pressing up on the sinciput during pains, by attempting to hook the occiput forward, etc. Manual rotation of the head under anesthesia, supplemented by rotation of the body, is often satisfactory. The body is rotated by shoving the posterior shoulder anteriorly by the vaginal hand, while the other hand on the abdomen brings the anterior shoulder to and past the midline. The case may then be left to nature, or delivery may be completed by forceps. Version may be employed in suitable cases, especially in multiparæ. Forceps are at times indicated when the head is well down and less radical methods have failed. We have been well pleased with the Scanzoni method, which is strongly favored by Williams. He states, however, that it is necessary to resort to forceps in only about one percent of the cases of posterior positions. De Lee does not like the Scanzoni manœuvre, and applies the forceps obliquely, one blade lying on the parietal bone, the other on the malar; traction is made, and the forceps are readjusted as descent and rotation occur. I think that the objections raised against the Scanzoni application are due to a misunderstanding as to the details of the technique. It is generally stated that the forceps are rotated after being applied. In our hospital and private work we have learned not to rotate, and we are told that this is the teaching of Scanzoni's original paper. We employ the method as follows: the forceps (not the axis-traction type) are applied to the sides of the head, the pelvic curve looking toward the child's face. Traction is made in the axis of the pelvis, but no rotation is attempted. As the head comes down, it usually rotates anteriorly, carrying the forceps with it. This rotation is at times not complete until the head is well down on the perineum. When it is complete, the instrument is on upside down, as the occiput is now under the symphysis, so the forceps are taken off, reapplied in the usual manner, and the delivery is easily finished. If the head does not ro-



tate anteriorly with simple traction, but rotates posteriorly, we let it do so, and deliver in that position. In the third class of cases, in which the head is well down at the outlet, but still in the oblique or transverse diameter, we may try backward pressure on the anterior temple during pains, with forward pressure on the occiput, or we may even then rotate by Scanzoni's method. Most of these cases will be delivered as sacro-posteriors, either spontaneously or with forceps.

In other words, the treatment is, first of all, expectancy, with the patient preferably lying on the side to which the occiput points. The great majority of the cases will deliver spontaneously. If not, manual rotation, preferably by combined manipulation, may be tried, followed at times by forceps and extraction. Version is indicated in appropriate cases. When the head is well down, the Scanzoni manoeuvre is most useful. And the few cases which rotate into the hollow of the sacrum are delivered either naturally or artificially with the occiput directly posterior.

Since the first of the year, I have handled 23 occipito-posterior cases in private work and a few at the Charity Hospital along these lines. 17 rotated spontaneously, most of these after being placed on the appropriate side. And here let me state again that multiparæ are prone to rotate and deliver at times with lightning-like rapidity after being placed in this position. Three rotated into the hollow of the sacrum; one delivered spontaneously, and two were delivered by forceps; one of these was stillborn. Two were delivered by Scanzoni's method. One L. O. P. case rotated until the occiput pointed to the left acetabulum, and stopped; rotation was completed and delivery effected by forceps. One baby out of the 23 was stillborn after a difficult forceps delivery, with final rotation into the hollow of the sacrum. The posture above outlined is of the greatest value; for example, one primipara delivered herself of a ten pound baby with the cord three times around the neck two hours after being placed on the right side. More active treatment, I am sure, would have cost us the baby's life. Next in favor, in suitable cases, is the Scanzoni manoeuvre; manual reposition, version, and other manipulations may be successfully employed when indicated. Let us bear in mind that most of the cases will rotate spontaneously, if we wait long enough; in a few cases, however, delay beyond a certain point will be injudicious, and will cost us the baby's life.



**MENACE TO PUBLIC HEALTH.\***

By DR. OSCAR DOWLING, President of the Louisiana State Board of Health.

I have gathered for this evening some figures on five of the diseases which seem at present to be a menace to public health, perhaps more particularly than any other of the communicable diseases which are controllable.

The records of the State Board of Health for 1919 show, for the entire State of Louisiana, the following:

	Cases	Deaths
Smallpox .....	1,121	471
Pulmonary Tuberculosis .....	1,579	2,326
Gonorrhœa .....	5,153	7
Syphilis .....	2,664	262
Chancroid .....	803	.....
Total.....	11,320	3,066

For 1920, for the entire state up to September 30th, inclusive, the following:

	Cases	Deaths
Smallpox .....	1,192	137
Pulmonary Tuberculosis .....	1,270	1,742
Gonorrhœa .....	3,350	11
Syphilis .....	1,951	178
Chancroid .....	717	.....
Total.....	8,480	2,068

For New Orleans for the year 1919, the records are:

	Cases	Deaths
Smallpox .....	98	5
Pulmonary Tuberculosis .....	1,293	812
Gonorrhœa .....	2,312	3
Syphilis .....	1,555	87
Chancroid .....	434	.....
Total.....	6,692	907

For New Orleans for 1920 up to September 30th, inclusive:

	Cases	Deaths
Smallpox .....	686	109
Pulmonary Tuberculosis .....	954	575
Gonorrhœa .....	1,437	6
Syphilis .....	1,125	49
Chancroid .....	408	.....
Total.....	4,610	739

\* Read before the Orleans Parish Medical Society, December 27, 1920.

Based on weekly reports up to December 18th, there have been in New Orleans during 1920, 848 cases of smallpox and 123 deaths.

Statistics of the Bureau of Venereal Diseases from December, 1919, to November, 1920, show a total of 8,033 cases—3,994 white, 4,039 colored. The figures of the deaths given above do not cover this period, but they are sufficiently significant to indicate the death rate.

I need not present to you arguments concerning the appalling menace which Tuberculosis is at the present moment to the people of Louisiana. I am sure you are sufficiently familiar with the situation to realize its gravity.

Neither do I need to present any data to convince you relative to results of compulsory vaccination, but, for your information, it may be interesting to know that figures gathered for a period of four years of European countries show, in a population of 175,200,000, without compulsory vaccination there was an average per million of 2,422.5 deaths from smallpox; whereas, for the same period, in a population of 39,600,000, there was only an average per million of 24.5, with compulsory vaccination.

I assume you are familiar with the army records in relation to the lowered percentage of cases of venereal diseases among the soldiers wherever preventive measures were put into effect. The purpose of these figures is to bring before us the situation. I think they clearly do so, and the second point we have for consideration is, what we can do by cooperation to control the present situation and prevent further spread of these and other communicable diseases.

The situation having been considered, the second point is the remedy, or suggestions. I feel sure you know the dire need for better health organization for the units of the state—community and parish, outside of New Orleans. There are a few communities and parishes—very few, I am sorry to say, where the people have sufficiently awakened to pay a living salary to the health officer, but in the main the state is without efficient service because of the lack of appropriations to pay men who would give their full time to the work. Another weakness of the present situation is the lack of sufficient machinery on the part of the State Board to meet every emergency. This also is due to lack of funds. I think, however, present conditions may be improved by a closer cooperation

between those who are in responsible public health positions. The city and state offices at present are fairly in touch with each other. The state office receives weekly totals of communicable diseases, and if an epidemic be imminent, of typhoid fever, for example, where the State wishes to help in running down the source or in making an investigation of contacts, the files of the city are open to our office. This makes it practicable for the state to give assistance in an emergency.

We lack prompt reports from Charity Hospital of names and addresses of persons who come from without the city to the hospital for treatment. It is our duty to notify Parish and City Health Officers, and we should have these reports in detail and as promptly as possible, of all contagious diseases.

We should also have from the city office reports of cases of venereal diseases where the persons are residents of Louisiana, but not of the city. If there are patients of this character there should be daily records of them, and we should have weekly records from the city office of the doctors' reports of cases that have originated outside of the city, or of persons who have come from places outside of New Orleans.

We should avoid duplication of effort. The city office should have complete reports of all communicable diseases, venereal diseases included, and if the machinery of the City Board is adequate for the taking care of all of these cases, venereal cases included, the state office should be relieved of any responsibility concerning them, except, as before stated, where they originate outside of the city.

I think it would be well for the Superintendent of Public Health to be Assistant Collaborating Epidemiologist, as this implies the franking privilege for all reports from physicians. Supplies are sent from Washington, and it leaves no excuse on the part of physicians for a lack of reports.

It is also apparent that tuberculosis cases from outside the city should be reported to the State Board, that these, too, may be in turn reported to the local officials.

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**PROCEEDINGS OF THE STAFF OF TOURO INFIRMARY  
HELD AT TOURO ON DECEMBER 8, 1920.**

*Dr. C. L. Eshleman:* Case 1. The first case is that of this young man, 34 years old; who came before me for the first time about two years ago, complaining of having had digestive troubles since 1914, hunger pain at various times, recent hematemesis and tarry stools. In addition, he had had "frequent attacks of cold and cough" and had been at one time sent West by his physician on account of his lungs—tuberculosis? He remained West for three months and returned home improved.

When I saw him, therefore, with these gastric symptoms, he had a bad history and there was slight impairment of resonance at the apices of his lungs, but no distinct evidence of any active lesion. The diagnosis at this time was gastric ulcer, and possibly arrested pulmonary tuberculosis. I did not see him or hear from him again until two weeks ago. At this time, he told me that he had had some digestive symptoms and tarry stools during the two years, but his chief complaint was the severe, persistent loose cough with much purulent sputum and weakness. A cursory examination on the night of his admission showed that he had lost considerable weight, looked weak, was coughing and expectorating profusely and his lungs showed broncho-vesicular breathing and extensive fine moist rales. The next day a more detailed history brought out that while he still continued to have gastro-intestinal symptoms at times, he had been troubled greatly with repeated "attacks" of "fresh cough and cold" and he was definite in his assertion that at times he was entirely free of any cough. This is not usual in cases of tuberculosis and aroused my suspicions. His present cough had been of six weeks' duration and had started with high fever and he had been confined to house and bed during most of that time. His lungs were as reported, and he had expectorated during the night nearly an ordinary sputum cup full of muco-purulent material. I was undecided at this point whether we were dealing with T. B. or not and began to think of other kinds of pulmonary infection—especially as his right upper lip showed a healing skin lesion very suggestive of a recent herpes labialis which is more commonly associated with pneumonias than other diseases. He was also non-febrile at this time and a single examination of sputum had so far shown



no acid fast bacilli. A leukocyte count was 13,500. I thought an X-ray of his lungs would be interesting. Drs. Samuel and Bowie thought it somewhat suspicious of T. B. but were unwilling to make a definite diagnosis. We decided to make another plate in ten days.

In the meantime, he got on much better, continued absolutely non-febrile, coughed much less and expectorated much smaller amounts of less purulent looking material, repeated examinations of which showed no tubercle bacilli, and his lung condition improved with disappearance of the fine crackling rales and broncho-vesicular breathing, but a marked bronchitis has persisted.

Evidently, we were dealing with a resolving broncho-pneumonia plus some chronic gastro-intestinal condition which had already helped to debilitate and emaciate him. This gastro-intestinal condition has not yet been worked out because his pulmonary symptoms have been so much in the foreground. A Reyfuss fractional gastric analysis recently shows a probably normal curve. He has had no blood in stools so far.

I thought he might prove interesting merely on account of the fact that at first he seemed to be a case of advanced pulmonary tuberculosis which turned out otherwise.

Cases 2 and 3. Both of these cases are malignant growths of the lung but they have presented themselves in rather a different way. In case 2, I can only give you some of the history and show his X-ray plate because the patient recently returned to his home in Texas. The other case will be brought in later.

Case 2. This man had first consulted Dr. Lynch for a complete aphonia which the doctor found to be due to involvement of the vocal cords by a malignant growth. Subsequently, he developed stertorous breathing and obstructive laryngeal signs and Dr. Lynch put a tracheotomy tube in place and asked me to examine him preparatory to the laryngectomy. He was having temperature from 99 to 101 degrees and coughing in the manner that all tracheotomy cases do. Interpretation of breath sounds after a tracheotomy is not always easy on account of the noisy breathing and ronchi in the tubes. The most striking physical sign to be detected was a slight amount of dullness at the base of right lung and slight diminution of the breath sounds over the same area. There was a general bronchitis following tracheotomy but these physical signs at his right base were enough to create some suspicion. They might have been due to a thickening of the pleura at this point from some old pulmonary infection, but I thought it advisable to ask for a skiagraph before the laryngectomy was attempted. You will see the wisdom of this by noting the very distinct areas of metastasis at the base of the right lung and spreading upward somewhat toward the

apex also. It was considered unwise to do the laryngectomy under these circumstances. This is, therefore, merely a case of secondary carcinoma of the lung showing itself shortly after the primary involvement appeared in the larynx, not an uncommon manner to meet carcinoma of the lung.

**Case 3.** This case has been in the hospital since November 17. I am indebted to Dr. Weis for the opportunity of presenting him. He has a malignant growth of the lung also, but I think it is more likely a primary condition than a metastatic one as in Case 2. Whether it is carcinoma or sarcoma it is impossible to say. Primary carcinoma of lung was formerly considered rarer than sarcoma, but this is not the case.

He is 58 years old. Family history is negative. There has been no previous illness, which might throw any light on the present condition.

#### DISCUSSION

*Dr. Randolph Lyons:* A word about the first case particularly with reference to the importance of correlation between radiologists and physicians. Owing to the epidemic of influenza during the past two years, many changes have taken place in the lungs of persons who have had that disease. These changes do not, however, affect the individual who had influenza, but radiologically, the lungs will show permanent pathological changes.

In St. Louis, I had the opportunity of seeing a number of lung sections which had been prepared by Dr. Opie, demonstrating various lesions of influenzal pneumonia. Many of the sections showed marked involvement of the lymphatics, others changes in the bronchiole leading to bronchiectasis, others showed marked fibrosis. It is not to be wondered then that many individuals who have had influenza subsequently have attacks of bronchitis. If such a case is X-rayed the lungs will show marked changes which might well be supposed to be due to tuberculosis. If such a case, however, is carefully examined by the physician, the sputum will be found to be with negative tuberculin reactions. It has been my custom during the last year to discuss and examine with our radiologist all cases showing lung pathology with radiological findings and to try to correlate them as much as possible.

**Dr. S. K. Simon** reported a case of carcinoma of the lesser curvature of the stomach originating near the cardiac end with extensive metastasis. This patient was 56 years old, an engineer helper. He gave a history of having been taken sick in June of this year with mild gastro-intestinal disturbances. Physical disability was an early development and the patient became bed-ridden within two months of the onset. He entered the hospital service on September 9, 1920, and presented a picture of a moderately severe toxemia. The temperature ranged from

99½ in the mornings to 102 in the afternoons. The principal symptom was an excruciating, lancinating type of pain in both shoulders and along the dorsal spine. Objectively, nothing could be made out. The gastric analysis revealed achylia gastrica but there was no motor insufficiency and no obstructive signs at the cardia. The blood picture was that of mild secondary anemia with moderately high leukocytosis (10,000 to 15,000). No glandular enlargements could be made out. The X-ray examinations of the gastro-intestinal tract were negative. A diagnosis of hypertrophic arthritis of the lumbar spine was made by the radiologist. This could not, however, be considered as the main source of trouble. The real nature of the disturbance was finally revealed about one month after admission. A tumefaction developed over the right thoracic region which rapidly increased in size. At first thought to point to hepatic abscess, aspiration failed to reveal pus. A pathological fracture of the sixth and seventh ribs in the liver region eventually occurred which made it certain we were dealing with a malignant growth involving one of the visceral organs. At autopsy, a carcinoma of the lesser curvature was found in the neighborhood of the cardia without, however, blocking that orifice. Extensive metastasis of the thoracic and retroperitoneal glands was present and likewise metastatic nodules in the heart muscle, liver, spleen, pancreas and peritoneal cavity.

Several interesting features characterized this case. (1) The extensive metastatic involvement representing a general and diffuse carcinomatosis. (2) The prominence of the toxic features from the onset. (3) The absence of all objective signs in the stomach. (4) The negative radiological report in spite of the rather extensive involvement found at autopsy in the lesser curvature. (5) The prominence of the neuralgic pains along the spine and in both shoulders in the absence of all pain in the abdomen or thorax. (6) The occurrence of a pathological fracture of the ribs yielding the first definite evidence of malignancy.

#### DISCUSSION

*Dr. Lanford:* Carcinoma of the lesser curvature of the stomach is very difficult to recognize before death. I have seen two autopsies during the past year of this condition and neither diagnosed before death. This case was of particular interest on account of the method and route of its metastases. The primary growth was situated in the upper left side of the lesser curvature but did not encroach upon the esophageal junction. The metastasis had taken place by continuity of tissue and had involved all the structures in the lesser peritoneal cavity, extending over to the spleen, and involving the greater portion of the pancreas, and to the right to the under surface of the liver. Its lymphatic metastases were most striking downward as all the lymph nodes in the peritoneal



cavity and retroperitoneal space were involved, down to the iliac vessels.

Another unusual condition was that the lung was not involved, either grossly or microscopically, but there were some metastases in the musculature of the heart, varying in size from two to six mm in diameter and located mostly in the right auricle and ventricle. There were also about five metastases in different ribs; three on the right and two on the left, the one on the right side involving the seventh rib had caused a fracture of this rib. The involvement of the ribs and adjacent structures probably explains the neuritic pains.

**Dr. C. A. M. Dorrestein:** White female, age 60 years, housewife. Entered hospital November 3rd complaining of a dull aching pain in lower abdomen, especially on right side—and a vaginal discharge; fever and loss of weight, about 50 pounds in five weeks.

Pain was first noticed about two months ago and lasted for four or five days. Since that time she has had frequent attacks which would last several days and then disappear. Lately the attacks have increased in severity and for the past week have been continuous, accompanied by a purulent, foul-smelling vaginal discharge, grayish in color. She has suffered with constipation since moving South three years ago, worse in the summertime.

**Family history negative.** Four children living and well.

**Previous history.** Usual diseases of childhood.

**Medical.** Has complained of constipation for 25 years. Began menstruating at 15, always regular; ceased age 45.

**Physical Examination.** Patient well developed and in a fair state of nutrition. Lungs and heart normal. Abdomen: no rigidity, wall rather thin; slight tenderness, low, upon deep palpation. No masses palpable, nor liver, spleen or kidneys.

**Pelvic Examination.** Increased resistance in vaginal vault. Mass behind uterus; adherent; pyometra.

**Laboratory Examination.** Hemoglobin 70%; white blood cells 14,700; with 84% polymorphonuclears. Erythrocytes 3,975,000. Urine showed numerous pus cells and an occasional red cell.

Tentative diagnosis—Pyometra.

A panhysterectomy was done on November 9. The uterus was carcinomatous and adherent to bladder and rectum with a perforation about 3 c.m. in diameter through posterior wall into the peritoneal cavity.

The pelvis was filled with sloughs and a small amount of pus. Cause of pyometra not determined by Pathological Department. Operation did not improve general condition. Patient died on November 13 with general septicemia.



## DISCUSSION

*Dr. D. N. Silverman:* An interesting point in the history of this case was its sudden onset but two months previous to operation. There was no history of fever up to two weeks prior to admission. There had been some bleeding from the rectum a few months before the case came under observation. At the time of examination, a mass could be felt about two inches above anal margin, pressing upon the anterior portion of the rectum but not involving this organ. No reason was detected for the presence of blood in the stools.

*Dr. L. H. Landry:* I would like to say a few words about a case of gangrenous appendicitis. He came in with a ruptured appendix which was removed and drained. This was followed by a large, retrocecal abscess which also had to be drained. A few days following this, he developed a sudden hemorrhage which was quite alarming and was returned to the operating room. However, on exploration, the hemorrhage was found to be caused by a ruptured or eroded epigastric artery. This was easily controlled. He apparently was getting over this when it was discovered that he had metastatic abscesses in the liver. This was more than he could stand as he had been considerably debilitated by his long pus infection. Patient died about six weeks after his original or primary operation.

*Dr. F. W. Parham:* A very interesting case. This man came to my office originally, complaining of pain in left side over back part of lumber region. At the time as I thought it was just myalgia, but took his temperature which was found to be 101. He wanted to go home which I allowed him to do. Next day he was no better; Dr. Bradburn went to see him. Reported such a condition, temperature 102, Ambulance was sent for him. Leukocyte count was 18,000; took away the idea of simple myalgia. Examination revealed no sign of real pain, but on palpation I found pain to be posterior on right side. Changed to front after a while. I was unable to make a tentative diagnosis at the time. Tentative diagnosis made by Interne "appendicitis". He developed gradually a little swelling in the right lumbar region below costal arch, which could be made out by the thumb behind and fingers in front. Liver at that time showed enlargement, no tenderness over intercostal space. No sign of edema,

but as I felt this induration below ribs, I put a needle in. Found pus. Next morning, took him into operating room and made incision about one inch below rib and found that this was a projecting liver. Then sewed liver up to the wall below and took two or three stitches above to shut off subphrenic space and opened it. Found a large abscess of liver. Leukocyte count at that time about 20,000. High differential count 90, sometimes as high as 95. After abscess was opened, no improvement took place. Began to complain of pain on other side and I found a swelling in the region of the left kidney. I opened that finding a large quantity of pus which was perinephral. Improved but leukocyte count remained high. Developed same evening a temperature nearly 103. I have punctured the liver in a number of places on the right side and lower part of chest on right side, left pleural cavity. I have made careful search everywhere and no evidence of pus found. Strange to say, the man has shown latterly some signs of improvement. Liver decreased in size. Subsequently made an incision, put drainage tube from front through liver and brought out in eleventh intercostal space behind. Man has a tremendous appetite and, encouraged by Dr. Lemann, eats everything except cabbage. Unable to find any other focus. Had seen man previously with a nail puncture of foot, occurring eight days before, and considerable abscess which I opened. I believe that was the starting point of his infection through metastasis. From one point to another, multiple abscesses of liver.

**Dr. Gessner** presented a case of "Thyrotoxicosis." Patient died after operation. Age, 23 years. Had diagnosis made by physician in country. Rested for two months. No improvement. When she came here, she presented a typical hyperthyroid condition—enlarged neck, exophthalmus, rapid pulse, usual lid signs, moderate degree of tremor. She had a sign which is frequently described in articles but seldom seen by me—a tendency to diarrhea. A Goetsch test was made; her reaction to Adrenalin was moderate. Operated next day—excision of lobes, symmetrical. Pulse ran to 160 but came down to 150. Sent her to ward in good condition. After going to ward pulse began going up, to a rapidity which seems almost impossible to count—200. Cyanosed. Pulse remained very high and began to lose in volume. 1 hour after operation, in spite of saline infusion, she died.

Dr. Leake brought up a point—what lessons can be learned from the study of fatal cases. In this case, preliminary ligation of poles would have been a better thing to do. Two tests can be made in these cases; one the Goetsch and the other, that of metabolism.

The Goetsch test reaction was so mild it seemed a case for final operation. If I had the case to do over, I would do a ligation and when it improved, would proceed to do a resection.

#### DISCUSSION

*Dr. Lyons:* The Goetsch test has not been accepted as entirely reliable of Thyroid function. He himself said in his last article that in very marked cases of exophthalmic goiter this test was frequently negative. The fact that Dr. Gessner's patient reacted so slightly should probably have been interpreted as an index of extreme toxicity.

*Dr. Gessner* also reported the case of a man 73 years old, mild degree of intestinal obstruction. Repeated enemas brought results; passed blood by rectum which apparently did not come from anus; there were no hemorrhoids. X-ray picture was suggested. Opaque meal stopped at hepatic flexure. Opaque enema also stopped at hepatic flexure. There appeared to be some ulceration of bowel. Operation was suggested. Family asked for consultant and he agreed to opening abdomen. Examined intestine especially the colon from appendix to rectum and found nothing abnormal in the bowel. This is just one of the cases in which the X-ray misleads us. Result recovery. Time between X-ray examinations was a week or ten days. Mild degree of obstruction relieved by enema. Presumptive diagnosis, carcinoma of bowel.

#### DISCUSSION

*Dr. Parham:* I made a diagnosis years ago in a case of partial obstruction of colon. Patient at Battle Creek for 7 weeks and Dr. Case, who is well known as roentgenologist, corresponded with me on the subject and put it down as a case of ileal stasis with incompetent ileocecal valve. Says about one person in six has an incompetent ileocecal valve permitting regurgitation. Did not lay sufficient stress on pain indicating partial obstruction. There was no pain in Dr. Gessner's case. Did not believe ileal stasis would be sufficient to explain. Man died subsequently. I refused to operate because something else had developed—tumor on left side. Autopsy showed intussusception of one meter of jejunum, entirely gangrenous. Dr. Lanford, who held the autopsy, found in the splenic flexure of colon old ulcer with contraction producing partial constriction. In that case it was a mistake of the roentgenologist who had not read the pictures properly. Dr. Case said this might be set down as evidence against roentgenology but it was the fault of the roentgenologist himself—the picture showed it but the roentgenologist failed to read it properly. Diagnosis: Colonic obstruction rather than ileal stasis.



*Dr. Wm. Kohlmann:* Case was that of lady 50 years old who came in with partial obstruction of intestine. She came in complaining of "cramps in the stomach." Entered November 12. First time she noticed these "cramps" was last September. Pain came on slowly with no nausea or fever. She had much gas and occasionally would notice a finger-like projection rising up in the abdomen below the umbilicus and the left. The elevation and "cramps" would come on synchronously. First attack lasted 24 hours. Reoccured three weeks later, accompanied by nausea and vomiting. Occasionally, sour stomach and stools rather white. When very severe, she noticed pain in gall-bladder region. He had seen the case before. She had been operated on 22 years ago for some apparent pus collection in the side—retroperitoneal abscess as well as he remembers. She has had no illness previously. Questioned carefully as to typhoid, gastro-intestinal condition. Made physical examination; well developed woman, pale, slight touch of jaundice. Lungs negative. Extra systole. No abnormal distention in abdomen. Some tenderness on palpation just below the umbilicus and about two inches to the left. Could feel contraction of small intestine, elevations of abdominal wall; complained of "cramps" as she termed it. Total blood count, white five and one half thousand. 8% eosinophilia. Immediately made examination of stool. Absolutely negative for ameba, parasitic ova and occult blood. Gastro-intestinal series run which showed nothing. Watched her for about twelve days trying to come to some conclusion. She had spells of constipation which lasted for several days. Twelve days after she came laparotomy was done and intra-abdominal examination revealed a hard mass in the lumen of the small intestine, low in the jejunum. Rather hard, nodular, about  $\frac{3}{4}$  size of hickory nut. The intestine which was hanging down on the left side in the pelvis was brought up and right at this place was found a stenosis of the intestine which reduced the size of the lumen to less than half the size. Just back of the stenosis was this hard mass. Incised into the lumen and delivered this mass which was nodular and proved to be a fecal lith. It would get jammed and cause the gas to form, peristalsis and pain. A side to side anastomosis was done—put in a button. Practically normal recovery. Area showed no gross signs of malignancy. Fluoroscope and skiagraph of abdomen showed no signs of button. No report of having passed button.



ANALYSIS OF HOSPITAL SERVICE.

(Representing all discharges in November, excepting admissions prior to July 1, 1920.)

Department	Total	Cured	Improv.	Stat.	Died 48 hrs.	Total Dead	Infections		Agree	Disagree	Diagnosis		Tent. Not given	Consul- tations
							Instl.	On Adm.			Addl.	Addl.		
Ear, Nose and Throat.....	142	120	14	7	0	1	....	....	141	0	1	0	2	
Eye .....	16	2	11	3	0	0	....	....	15	0	1	0	1	
Gastro-Intestinal .....	25	8	12	4	0	1	....	....	18	4	3	0	4	
Gynecological .....	94	43	43	7	0	1	2	....	83	6	5	0	1	
Medical .....	19	5	10	4	0	0	....	....	16	2	1	0	4	
Neurological .....	18	1	8	8	0	1	....	....	11	3	1	3	4	
Obstetrical .....	44	41	0	3	0	0	....	....	44	0	0	0	0	
Newborn .....	39	37	0	0	2	2	....	....	39	0	0	0	0	
Stillborn .....	1	0	0	0	0	1	....	....	1	0	0	0	0	
Orthopedic .....	11	0	11	0	0	0	....	....	11	0	0	0	2	
Pediatric .....	6	3	2	1	0	0	....	....	3	1	0	2	0	
Skin .....	2	0	2	0	0	0	....	....	2	0	0	0	0	
Surgical .....	180	112	45	11	3	12	4	4	153	12	14	1	8	
<b>Total.....</b>	<b>597</b>	<b>372</b>	<b>158</b>	<b>48</b>	<b>5</b>	<b>19</b>	<b>6</b>	<b>4</b>	<b>537</b>	<b>28</b>	<b>26</b>	<b>6</b>	<b>26</b>	

## NEWS AND COMMENT

**TRAINED NURSES LICENSED.**—At the semi-annual examination of the Louisiana State Board of Examiners, held simultaneously at Shreveport and New Orleans, December 13 and 14, eighty-five applicants qualified as registered nurses. The Louisiana Nurses Board of Examiners is composed of the following doctors: Dr. J. T. Crebbin, President; Dr. J. S. Hebert, Sec'y-Treas.; Dr. G. S. Brown, of New Orleans, and Dr. F. J. Frater, of Shreveport.

**MEMORIAL TABLET TO DISCOVERER OF YELLOW FEVER ORGANISM.**—The authorities of Guayaquil have ordered that a tablet be placed in the bacteriologic laboratory of the Public Health Department of Guayaquil to commemorate the discovery of the causative organism of yellow fever. The inscription reads as follows: "In this laboratory of the Public Health Service, the prominent Japanese bacteriologist, Hideyo Noguchi, member of the Rockefeller Institute discovered the yellow fever organism, July 24, 1919."

**DISTRIBUTIONS BY THE CARNEGIE FOUNDATION.**—The Carnegie Foundation for the Advancement of Teaching distributed up to June 30, 1290, the sum of \$7,964,000 in 664 retiring allowances and 245 pensions to widows of professors in 159 universities and colleges. This announcement has been made to the Trustees by Dr. Henry S. Pritchett, the President. The Foundation's assets are \$24,628,000. The Teachers Insurance and Annuity Association, established by the Foundation, during its first two years had provided for teachers in 213 institutions, 585 policies totalling \$2,969,000 and 513 annuity contracts representing \$540,000, or a total expected payments of \$6,480,000.

**NEW RADIUM INSTITUTE.**—The Hotel Dieu Radium Institute consisting of members of the staff of the Hotel Dieu, New Orleans, has been formally opened. This makes the fourth radium institute which has opened in New Orleans within the past few years, the others being the Radium Institute of New Orleans, the Polyclinic Radium Institute and the Southern Radium Clinic, Inc.

**NEW TUBERCULOSIS SANATORIUM DEDICATED.**—The grounds, comprising 54 acres of land, donated by Col. J. B. Ardis and his family, situated at New Pines near Shreveport, have now a new building on them which will serve as a sanatorium for the treat-

ment of tuberculosis, said building having been dedicated by formal exercises on December 4. The sanatorium with its auxiliary structures represents an investment of over \$100,000.

CENTRAL MISSISSIPPI MEDICAL ASSOCIATION, composed of the counties of Hinds, Rankin, Madison, Yazoo and Simpson, held its annual meeting on December 21, at Jackson, Mississippi, and elected the following officers: President, Dr. R. H. Hall, of Hinds; Vice-President, W. S. Hamilton, of Hinds, H. W. Watson, of Rankin, E. A. Cheek, of Madison, John Barlington, of Yazoo and R. W. Burnett, of Simpson.

IMPROVEMENTS AT ST. LOUIS UNIVERSITY.—Announcement has been made by the President of the St. Louis University that Dr. John Auer, pharmacologist of the Rockefeller Institute of New York, has been secured to institute and conduct a Department of Pharmacology in the College of Medicine of the University. It is the hope of the faculty of the University to be able, through the Centennial Endowment Fund of \$3,000,000 now being raised by the friends and alumni of the institution, to establish complete departments in every line of medical instruction and research.

HIGHEST RATINGS FOR LICENSURE.—At the recent examination for licensure conducted by the Missouri State Board of Health, members of the Class of 1920 of the St. Louis University College of Medicine were awarded sequentially the fifteen highest ratings in a class of eighty-five candidates representing twelve universities.

FRANCO-ANGLO-AMERICAN CANCER LEAGUE.—This league, which was organized in Paris in 1918, is made up of a group of wealthy and influential persons and it is claimed to be "the first institution founded with scientific and philanthropic object as the result of an understanding between the three great allied nations," according to a statement printed in the first announcement of the formation of this league. The major interest will be in the establishment of hospitals, laboratories and other institutions for the control of cancer. The league numbers among its council of administration the following: M. Justin Godart, ex-Under-Secretary of State for the Service of Public Health; Professor Hartmann, of the Academy of Medicine; Sir John Pilster, Honorary President of the British Chamber of Commerce; Professor Mark Baldwin, Foreign Corre-

spondent of the French Institute, and Baron Edouard de Rothschild.

**CONGENIAL OCCUPATIONS SUPPLANT MEDICINES.**—Reports from the Government tuberculosis sanatoria of the U. S. Public Health Service show conclusively the great value of occupational therapy as an adjunct in the treatment of disabled soldiers. Occupational therapy consisting of metal work and manual handicraft for curative and divertional purposes promises much in the medical care and treatment of those now being cared for by the Service. According to the report out of 392 patients admitted to one sanatorium 263 took occupational therapy and 129 did not. Of the former only two patients left the hospital against the advice of physicians in charge, while, on the other hand of the 129 who did not take occupational therapy, 83 either deserted or left the hospital against the advice of the physician in charge. This is less than 1 per cent. among the former, as against 65 per cent. among the latter class of patients. Occupational therapy is not vocational training but is given to bed patients and to those who are convalescing. When patients have completely convalesced this form of therapy is succeeded by vocational training.

**SULPHUR DIOXID IN CANDIES FORBIDDEN.**—The use of sulphur dioxide in even the most minute quantities in the preservation of confectionery will not be permitted by the Bureau of Foods in the State of Pennsylvania. The recent appearance of chocolate-covered cherries containing sulphur dioxide led to the issuance of orders to prosecute all dealers and manufacturers handling the adulterated confectionery. The sulphur dioxide is used to preserve the fruit but it is found to be deleterious.

**WARNING AGAINST TRICHINA.**—The U. S. Department of Agriculture has issued a warning against eating pork unless it is well cooked. Quantities of pork which being prepared at present on farms will soon be commercially disposed of and following this comes an increase in the number of cases of trichinosis so we are reminded that no matter how healthy the animal may be or how excellent the meat looks pork may nevertheless contain the germ. A rule tried out by a Danish investigator requires that the meat be cooked from 15 minutes in summer to 18 minutes in winter for each pound of weight, if put into boiling water and the water is kept boiling throughout the cooking process.



**MOBILE MEDICAL SOCIETY ELECTS NEW OFFICERS.**—At the annual session of the Mobile, Alabama, Medical Society, held on December 4, the following officers were elected: Dr. William H. Oates, President; Dr. Edward S. Sledge, Vice-President; Dr. Willis W. Scales, Secretary (re-elected); and Dr. Edley W. Cawthon, Treasurer (re-elected).

**OFFICERS OF OUACHITA SOCIETY.**—At the annual meeting of the Ouachita Medical Society held at Monroe, La., December 8, the following officers were elected: President, Dr. Courtland P. Gray; Vice-President, Dr. George W. Wright; Secretary-Treasurer, Dr. James E. Walsworth, all of Monroe.

**PRECAUTIONS AGAINST INTRODUCTION OF EPIDEMIC DISEASES.**—The spread of typhus, plague and cholera was prevented during the war by precautions in the restriction of commerce in countries of central Europe where such diseases were prevalent, but since the resumption of commercial intercourse these diseases have again begun to invade neighboring countries. Precautions have been taken, however, by the Public Health Service to prevent the importation of epidemic diseases into the United States and officers have been stationed at practically all of the important ports of Europe to inspect vessels and their crews and passengers prior to their departure for American ports. Stringent measures have also been adopted along the Mexican border to prevent the introduction of typhus fever.

**INTERNS WANTED FOR THE PANAMA CANAL HOSPITALS.**—Single men, between the ages of 22 and 30 years, American citizens, graduates of medical schools whose graduates are eligible for the Army Commissions, are wanted for duty on the Isthmus of Panama. Appointments will be made without civil service examination. Appointments will be for a period of one year, carrying compensation at the rate of \$75.00 per month, with free steamship transportation to and from the Isthmus free subsistence, lodgings and laundry. The work required is the same as that required in any of the large hospitals in the United States. The Ancon Hospital, with monthly admission rate of 900, and the Colon Hospital with monthly admission rate of 200, are the two hospitals in which service will be required. For further information address The Chief of Office, The Panama Canal, Washington, D. C.

FAR EASTERN ASSOCIATION OF TROPICAL MEDICINE.—The fourth Congress of the Far Eastern Association of Tropical Medicine will be held in Weltevreden, Batavia, in August, 1921. The President of the Board is Dr. Byker, the Vice-President, Dr. W. Th. de Vogel and the Secretary is Dr. H. M. Neeb, who is also the General Major of the Military Medical Service of Batavia. The papers will be classified in the following group of subjects: Tropical Physiology (Beri-beri); Protozoology (Helminthology); Cholera, Plague, Leprosy, Tuberculosis, Tropical Fevers, Dysenteries, Surgery, Obstetrics, Infantile Diseases, Climate, Hygiene, Sanitation and Quarantine, and others if necessary. All *titles* of contributions should be sent in at once; papers may be sent later on, and these may be in English, French or German. The subscription to the association of \$10.00 is to be paid in Phillip. Currency. A suitable program is being arranged for the entertainments of visitors during the Congress.

ACCIDENT PREVENTION TAUGHT IN AMERICAN SCHOOLS.—The study of Accident Prevention has been introduced into the public and private schools of twenty-nine of the most important industrial centers of the United States. Conclusive results have been obtained by this so-called "safety-instructions," as for example a reduction of 90 per cent. in the number of avoidable accidents in the Leigh Valley, Penn., industries. Several states have appointed committees with a view to rendering "safety-instruction" obligatory in all schools throughout the United States of America. It would appear to be of the utmost importance that habits of caution be instilled and the theory of safety taught in order later on to protect the children of the country from the dangers inherent to certain industries.

AMERICAN RED CROSS BUDGET FOR 1921.—Appropriations of \$48,200,000 have been made by the American Red Cross for the fiscal year 1921. These figures are \$21,000,000 below those of 1919-20. Thirty thousand victims of disaster were aided during the last fiscal year entailing an expenditure of \$900,000 in cash and supplies. Thirty temporary hospitals over 20 motor corps and 7 special relief trains were organized. The disasters in which the American Red Cross helped the victims were 73 in number, including 19 tornadoes and cyclones, 2 hurricanes, 2 cloud bursts, 1 hail storm, 2 earthquakes, 1 landslide, 15 fires, 1 explosion, 9 floods,

10 shipwrecks, 1 train wreck, 4 riots, 1 motor accident and 2 droughts, in which 850 people were killed, 1500 injured and about 13,000 rendered homeless. The value of the property destroyed was estimated at \$85,000,000.

**PHYSICIANS' HOME A WORTHY CAUSE.**—Prominent citizens of New York City are organized with a view to providing a home for aged physicians and their wives whom adversity has rendered dependent. This is not to be a local institution but is to be made country-wide as rapidly as interest grows and finances permit. Anyone interested in the development of the home should write to Dr. Robt. T. Morris, 616 Madison Avenue, New York City.

**MORTON IN THE HALL OF FAME.**—The list of names of persons elected to the Hall of Fame in the quinquennial elections by the Senate of the University of the State of New York includes that of William Thomas Green Morton for the accredited successful demonstration of ether anesthesia. Dr. Morton is thus the first physician who has been elected to the Hall of Fame in recognition of a medical achievement.

**NEW BOARD CHARITY HOSPITAL.**—On January 15, Governor John M. Parker announced the appointment of the following board of administrators for the Charity Hospital: Dr. Geo. S. Bel; Messrs. F. W. Evans, Sylvester Levy, C. C. Cowles, George J. Glover, Terrence Smith and William Pfaff. The last three are re-appointments and the term of an eighth member, J. P. Henican, has not yet expired.

**SURVEY OF DRUG ADDICTS.**—Clinics conducted by the narcotic division of the Bureau of Internal Revenue, through which agency several thousand drug addicts were examined, reveal no evidence of an increase of the narcotic habit since prohibition went into effect. The number of women habitues is slightly in excess of the number of men. The investigation disclosed that different communities have their favorite narcotics. In New York the addicts consume heroin almost entirely; in Chicago there is a predominant demand for morphin; in San Francisco, owing to the many oriental inhabitants, opium is most frequently employed, whereas St. Louis, New Orleans and other cities with a large colored population, cocain is found to be much in vogue. Field agents of the bureau have recently discovered small stocks of hashish.



CONGRESS OF MEDICAL EDUCATION AND LICENSURE.—The next annual Congress on Medical Education and Licensure will be held at the Congress Hotel, Chicago, March 7, 8, and 9, 1921. A joint program will be participated in by the Council on Medical Education and Hospitals of the American Medical Association, the Association of American Medical Colleges and the Federation of State Boards of the United States. Fifteen communities will present reports on suggestive courses of graduate training in the various specialties; reports on the medical curriculum will be presented by several committees dealing with the clinical subjects of the medical course, and other papers will deal with the National Board of Medical Examiners, and with problems of special interest to state licensing boards.

SPHAGNUM MOSS USED AS A SUBSTITUTE FOR COTTON IN SURGICAL DRESSING.—From time immemorial bog moss has been used by country people in the treatment of boils and of discharging wounds. It has been used in England, Scotland and Ireland for practically the same purpose as it is being used today in its revival in the late war. It was first brought into prominence by the importation of the sphagnum by Professor J. B. Porter, of McGill University. The Canadian Red Cross turned out upward of 200,000 sphagnum dressings per month. The total British output of sphagnum surgical dressing toward the end of the war is estimated to have been in the neighborhood of 1,000,000 while the sphagnum work of the American Red Cross was comparatively more because of the late date (summer of 1918) at which the first car load of this material was entered in the United States. The advantages of sphagnum over dressings made of cotton are many, among which may be noted the facts that it will absorb liquids more rapidly, about three times as fast, and will absorb more liquid, as well as retaining liquids much better than cotton, which means, of course, that sphagnum dressings need not be changed as frequently.

ALL THE HOSPITALS OF THE U. S. PUBLIC HEALTH SERVICE in the southwest are already crowded with tuberculosis patients and the influx of others continues so great that the Public Health Service has been forced to transfer patients from Tucson, Ariz., and other Western hospitals to sanatoriums near Asheville, N. C., and elsewhere in the East. Many ill-advised patients have of late



thronged to Tucson, unmindful of the fact that every hospital, hotel, and boarding house is overcrowded. More than 500 tuberculosis subjects in Tucson are unable to find entrance to a sanatorium. Other towns in the Southwest report similar conditions.

Surgeon General Cumming renews his warning against tuberculosis patients leaving sections where the government is able to care for them and going to the southwest on their own initiative.

NEW DIRECTOR FOR THE PEKING UNION MEDICAL COLLEGE.—Dr. Henry S. Houghton, a graduate of the Ohio State University and of the Johns Hopkins Medical School, has been appointed director of the Peking Union Medical College. Dr. Houghton has spent the greater part of the past fifteen years in China, where he has served as physician of the WuHu General Hospital, as Dean and Professor of Tropical Medicine of the Harvard Medical School of China in Shanghai, and, recently, as a member of the staff of the China Medical Board and Peking Union Medical College, which is controlled by a board of trustees chosen by the Rockefeller Foundation and by six co-operating missionary societies.

BIRTHDAY CELEBRATION OF PRESBYTERIAN HOSPITAL, NEW ORLEANS.—The twelfth birthday celebration of the Presbyterian Hospital, followed by the graduation exercises of nurses, took place in the Corinne Casanas Free Clinic building on January 14. The offering collected at the celebration, which took the form of a tea at which members of the Women's Auxiliary were hostesses, is to go into the fund for a new building which it is proposed to erect shortly. The ground now covered by the Presbyterian Hospital measures 287 feet front, by 184 and 115 feet respectively on the sides, assuring ample room for future developments. Last year the service to the poor at the free clinic consisted of the treatment of 7684 patients. The institution graduated eight nurses on January 14.

LOUISIANA AND MISSISSIPPI SECTIONS OF CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS.—The first annual session of the Louisiana and Mississippi Sections of the Clinical Congress of the American College of Surgeons was held in New Orleans January 10 and 11. The Louisiana Executive Committee is composed of Dr. F. W. Parham, Chairman, with Dr. L. H. Landry, Sec'y., and Dr. A. P. Crain, Counsellor. Clinics were held at all

of the hospitals in New Orleans and a resume of clinics was given at the Grunewald Hotel, after which several papers of interest were read. The next meeting of the association will be held at Atlanta, and then in Charleston, with the last meeting in Charlotte, North Carolina, completing the Southern tour of the organization.

**BOWDOIN MEDICAL SCHOOL.**—The Bowdoin Medical School, established a century ago by Maine's first legislature, will be closed as a department of Bowdoin College at the end of the current session unless it receives financial assistance. For this purpose it is estimated that an addition of \$25,000 will have to be made to the present resources to be used for equipment, and at least \$50,000 to be used as yearly income for more teachers and for up-keep. The trustees of the college believe that there is a place for a medical school in Maine and are hopeful of interesting the people of that state and the friends of medical education.

**MEDICAL HISTORY OF THE WORLD WAR.**—The Sundry Civil Appropriation Bill, just reported to the House, contains an item of \$50,000 for continuing the work of compiling the medical history of the World War, which is under the direction of Surgeon-General Ireland and Colonel Charles Lynch.

**PERSONALS.**—Dr. Ansel M. Caine announces the association with him of Dr. Ernest E. Allgeyer in the practice of general anesthesia and obstetrical analgesia.

Dr. L. C. Chamberlain has been appointed surgeon of the Police Department.

Mr. E. H. Walsdorf has recently been elected President of the State Board of Pharmacy; M. C. S. Daspit, Vice-President, and Mr. J. E. Guess, Secretary-Treasurer.

**REMOVAL.**—Dr. W. McDade has moved from Sibley to Minden, La., with office in the Joe R. Miller Building.

Dr. Espy M. Williams, from Patterson to Monroe, practicing urology.

**MARRIED.**—On January 11, 1921, in St. Louis, Mo., Dr. P. L. Querens, of N. O., and Miss G. S. Rives, of St. Louis.

**DIED.**—Dr. R. L. Randolph of Alexandria, La., during the past month, aged 59 years.

Dr. E. W. Mahler, of New Orleans, Secretary Louisiana State Board of Medical Examiners, aged 37 years, on January 22.

## MISCELLANY

### PROFESSIONAL INCOME.

To the professional man the problem of correctly making out an income tax return for the year 1920 is somewhat more involved than that presented to the salaried man. The wage earner on a fixed salary has an accurate estimate of the amount of compensation received for personal services, while the professional man's income varies from year to year. In the professional class may be included the physician, dentist, lawyer, architect, veterinarian, author and clergyman. Each must figure up his net income for the last year. If single or if married and not living with his wife and his net income was \$1,000 or more, or if married and living with his wife and his net income was \$2,000 or more, a return must be filed.

The exemptions are the same as for the year 1919. \$1,000 for single persons and \$2,000 for married persons living with husband or wife, and heads of families, plus \$200 for each person dependent upon the taxpayer if such persons are under 18 years of age, or incapable of self-support because mentally or physically defective. The period for filing returns is from January 1 to March 15, 1921.

The professional man must make a return of all fees, salaries and other compensation for services rendered, together with income from all other sources. If he keeps his accounts on the "receipts and disbursement" basis—which means a record of the amount received and the amount paid for expenses—he should file his income tax return for the year 1920 on that basis. If he keeps books showing income accrued and expenses incurred during the year, he must make his return from his books and include all income, even though not entered on his books. If books are kept on the accrual basis the taxpayer must include all income that accrued, even though not actually received, and may deduct items of expense, although not actually paid. Both the receipts and disbursement basis and the accrual basis are explained in instructions on the forms for filing individual returns of income.

This constitutes gross income from which the taxpayer is allowed certain deductions in arriving at net income upon which the tax is assessed. Among such deductions are the cost of supplies used by him in the practice of his profession, expenses paid in the oper-



ation and repair of an automobile used exclusively in making professional calls, dues to professional societies and subscriptions to professional journals, rent paid for office room, expense of fuel, light, water, telephone used in his office, and the hire of office assistants. Amounts expended for books, furniture and professional instruments and equipment of a permanent character are not allowable deductions. In the case of a professional man who maintains an office, but incidentally receives at his home, patients, clients, or other callers in connection with his professional work, no part of the rent of the home is deductible. If, however, he uses part of the house for his office such portion of the rent as is properly attributable to such office is a deductible item.

A reasonable allowance is made for depreciation, or wear and tear of equipment and instruments used by professional men. When through some new invention or radical change in methods or similar circumstances, the usefulness in his profession of some or all of his instruments or other equipment is suddenly terminated, so that he discards such asset permanently from use, he may claim as a loss for that year the difference between the cost (reduced by reasonable adjustment for wear and tear it has undergone) and its junk or salvage value. If the apparatus was owned prior to March 1, 1913—the date the first income tax law became effective—its fair market value at that date should be considered instead of its cost in figuring depreciation and obsolescence.

Deductions for uncollectible fees form an important item in the returns of many professional men. To be allowed as a deduction, a debt must be worthless and must have been charged off within the year in which its worthlessness was discovered. The return must show evidence of the manner in which discovery was made. For example, statement should be made that the debtor has been discharged from bankruptcy or has disappeared leaving no trace, or that all ordinary means of collections have been exhausted.

A debt proved to be worthless is not always a proper deduction. Unpaid amounts representing fees for professional services are not allowed as deductions unless included as income in the return for the year in which the deduction is sought or in a previous year. The fact that expected income was not received does not reduce the taxable income. If a debt is forgiven it cannot be deducted, because it is then regarded as a gift. A debt may not be charged



off or deducted in part, but must be wholly worthless before any part can be deducted.

Compensation in any form for professional services must be included as income. If a physician, lawyer, or other professional man should receive from a merchant goods in payment for professional services, the fair market value of such goods must be included as net income.

Forms for filing returns are now available at offices of collectors of internal revenue and branch offices. Collectors will mail to each person who last year filed a return a copy of the return form for 1920. Failure to receive a form, however, does not relieve a taxpayer of his obligation to file a return and pay the tax on time. Taxpayers whose net income for the year 1920 was \$5,000 or less should use Form 1040A. Those whose net income was in excess of \$5,000 should use Form 1040.

In addition to the individual forms, partnerships must file a return of income, or even if there was no net income, on Form 1065. Partnerships as such are not subject to the income tax. Individuals carrying on business in partnership, however, are taxable upon their distributive shares of the net income of such partnerships whether distributed or not and are required to include such shares in their individual returns. The return must show the name and address of each partner and his share of net income.

The tax this year as last may be paid in full at the time of filing the return—on or before March 15, 1921—or in four equal installments, due on or before March 15, June 15, September 15, and December 15. Payment may be made by cash, money order or check, which should be made payable to "Collector of Internal Revenue." The return must be filed with the collector for the district in which the taxpayer lives or has his principal place of business. Heavy penalties are provided by the revenue act for failure to file a return and pay the tax within the time prescribed by law.

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## BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Secy-Treas.

As Chairman of the Committee on Scientific Work I wish to announce the following Chairmen of the various Scientific Sections for the approaching Annual Meeting of the Society to be held in New Orleans, April 19, 20 and 21, 1921:

*Medicine and Allied Branches:* Dr. T. P. Lloyd, Shreveport, Chairman Section on Medicine and Therapeutics; Dr. C. J. Bloom, New Orleans, Chairman Section on Pediatrics; Dr. O'Hara, New Orleans, Chairman Section on Nervous Diseases; Dr. O. L. Pothier, New Orleans, Chairman Section of Health and Sanitation.

*Surgery and Allied Branches:* Dr. G. M. G. Stafford, Alexandria, Chairman Section on General Surgery; Dr. H. W. Kostmayer, New Orleans, Chairman Section on Gynecology and Obstetrics; Dr. F. C. Bennett, Monroe, Chairman Section on Eye, Ear, Nose and Throat, including Stomatology; Dr. H. W. E. Walther, New Orleans, Chairman Section on Genito-Urinary and Rectal Diseases; Dr. Ralph Hopkins, New Orleans, Chairman Section on Dermatology; Dr. L. J. Menville, New Orleans, Chairman Section on Radiology.

Any member of the Louisiana State Medical Society desiring to present a paper at the next meeting of the Society should get in touch, at once, with Chairman of the respective Section. We are very desirous of getting our program completed as early as possible and would therefore request that you attend to this matter promptly so as to expedite the formation of the program.

### COMMITTEE ON HEALTH PROBLEMS IN EDUCATION.

A very important conference was held in New Orleans during the past month, it being the initial meeting of the Committee on Health Problems in Education, of the Louisiana State Medical Society. Oh! what possibilities for good if this Committee will only function properly! Think of the immense benefit to our future citizenry (the present school children) if this Committee should be able to awaken all our School Boards and Health Boards to the needs of the schools along sanitary and medical inspection lines, by moulding public opinion! This can be done and *will be done* in time, but why not now?

This Committee has started to work by planning to take a census

of schools, colleges and universities in this State, ascertaining what is being done in each in regard to sanitary and medical inspections. In order to accomplish even this, the Committee needs the co-operation of all right-thinking citizens and, especially, of the Doctors, from whom they have a right to expect support. After all data has been obtained they expect to seek the aid of Health and School Boards and Child Welfare Organizations throughout the State, and to bring before every community the necessity of doing its duty toward its children.

This Committee will very shortly send out, through the State Board of Education, to every Parish Board of Education, a questionnaire, the returns of which will form the basis of their survey of the present status of Health Problems in Education.

This Committee expects and respectfully asks that every member of the Louisiana State Medical Society lend his support and influence toward making these returns a success. If any member should be approached by his Local Board of Education, we would appreciate it very much if he would assist in explaining any Medical Problems which are not satisfactorily understood by that particular Board. The function of this Committee is, first to secure this information and we feel assured we will receive support from Organized Medicine in our State.

This is not a LOCAL move—it is GENERAL. The American Medical Association has a Special Committee on the subject and every State Society is being urged to form one. These Committees have been called for a general conference in Boston, in June, 1921, during the American Medical Association meet, so as to unify aims and methods.

This is a big move in the right direction. It should succeed,—it is bound to succeed sooner or later so why not NOW?

A. A. HEROLD, M. D.,  
Chairman.

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## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the  
City of New Orleans, for December, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	2	1	3
Intermittent Fever (Malarial Cachexia)	1		1
Smallpox	11	7	18
Measles	9	1	10
Scarlet Fever	1		1
Whooping Cough			
Diphtheria and Croup	3		3
Influenza	1	2	3
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	37	27	64
Cancer	23	8	31
Rheumatism and Gout	1		1
Diabetes	5		5
Alcoholism	1		1
Encephalitis and Meningitis	1	3	4
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	26	14	40
Paralysis	5	2	7
Convulsions of Infancy	1		1
Other Diseases of Infancy	12	6	18
Tetanus			
Other Nervous Diseases	9	3	12
Heart Diseases	75	26	101
Bronchitis	3	2	5
Pneumonia and Broncho-Pneumonia	42	34	76
Other Respiratory Diseases	2	1	3
Ulcer of Stomach	3		3
Other Diseases of the Stomach		2	2
Diarrhea, Dysentery and Enteritis	13	2	15
Hernia, Intestinal Obstruction	2	2	4
Cirrhosis of Liver	1	5	6
Other Diseases of the Liver	5	1	6
Simple Peritonitis			
Appendicitis	5	3	8
Bright's Disease	25	14	39
Other Genito-Urinary Diseases	14	12	26
Puerperal Diseases	5	4	9
Senile Debility			
Suicide	3		3
Injuries	25	20	45
All Other Causes	22	18	40
TOTAL	395	220	615

Still-born Children—White, 32; colored, 18; total, 50

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 16.34; colored, 24.00; total, 18.45. Non-residents excluded, 15.78.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure.....30.10  
 Mean temperature.....54  
 Total precipitation.....8.70 inches  
 Prevailing direction of wind, southeast.



# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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**EDITOR:** CHAS. CHASSAIGNAC, M. D.

**COLLABORATORS:**

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## EDITORIAL

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### BENEFITS OF RADIOTHERAPY IN GOITRE.

In an excellent article, published recently in the *Bulletin Médical*, Belot, chief of the laboratory of radiology of the Hôpital St. Louis, shows the advantages of radiology in the treatment of goitre.

The symptoms of Basedow's disease, it is now well established, are due essentially to hyperthyroidism, hence any rational treatment must seek to modify the glandular secretion by diminishing its quantity and improving its quality. Radiology accomplishes this by destroying a portion of the parenchyma of the gland through the interposed tissues.

This is made possible by the different degree of sensitiveness exhibited by various tissues of the organism. Some, like the normal skin, do not retain a sufficient amount of radiation from a moderate dose of the rays to produce durable changes. Others, like the

thyroid body whose cells are in a state of great activity or proliferation, are easily destroyed by even a feeble dosage of the Röntgen rays. As the organ is relatively superficial and accessible, conditions are ideal for the successful application of the X-rays to the thyroid gland. Its secretory activity is gradually diminished, the most sensitive glandular elements are killed and, finally, are absorbed. Thus follows a progressive lessening of the toxic products which the thyroid body has been pouring into the organism.

Belot tells us regarding the technique to be followed that no absolute indications can be given as we must be guided by the symptoms present and the reactions which occur, but that success depends upon using very penetrating rays properly filtered. He uses a Coolidge standard tube with a spark of 22 centimeters filtered through 5 to 7 millimeters of aluminum. He makes the application first to the two lateral segments of the thyroid, covering the median segment and the thymus four or five days later, repeating the process every ten to twelve days.

The duration of the treatment depends upon the stage of the disease and the consistency of the gland. It does not extend beyond four months when the disease is recent and the thyroid is soft. It may reach six to eight months when the affection is chronic and the gland hard and fibrous.

The indication for the stoppage of treatment is found in the evolution of the disease, the diminished frequency of the pulse being one of the most easily appreciated differences; when the pulse remains for some time between 80 to 90, treatment must be slackened or stopped without awaiting the total disappearance of the tumor or of the exophthalmos, problematic after all, for fear of provoking a Röntgen myxedema through excessive destruction of the glandular parenchyma.

As the pulse slows down, the nervous manifestations diminish, sleep improves as well as the appetite, the articular pains are relieved, night sweats stop and the heart beats are less exaggerated. The exophthalmos is the most persistent symptom, rarely disappearing altogether.

Belot considers the patient cured when for two years the general condition remains good and the pulse does not exceed about 80. In typical cases, with classical symptoms a cure is obtained in 80%, rapidly in the acute form, more gradually in the chronic.

Surgical treatment should be reserved for the cases in which radiotherapy fails, for neoplasms, for cases of cystic goitre.

His conclusion is that radiotherapy properly applied is never dangerous and leaves no scar; that its use is seldom followed by relapse and that it should be considered the method of choice in most cases.

As it can do no harm, even if unsuccessful, and does not interfere with subsequent operation, it would seem best to give it a trial whenever immediate intervention is not indicated.

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### MEETING OF THE STATE SOCIETY.

We wish to remind the members of the Louisiana State Medical Society of the fact that the meeting takes place next month, in this city. Attention is called to the announcements contained in the Bulletin of the Society published in this issue as they comprise all the information available at this time.

Whether you are intending to present a paper, to discuss any subject or to be simply a good listener, your role is equally important in its way and your presence is as eagerly sought and you should make the same effort to be present.

As, on account of the meeting of the American Medical Association in this city, there was practically nothing but a business session of the society last year, there should be this year a double interest in the scientific work. The papers should be of higher merit and should be better discussed than ever.

Great preparations for the meeting are being made. Both the social and the technical features will be attended to and it is to be hoped that the expectation of professional profit and enjoyable relaxation at the same time will induce a large number to attend.

It is time for another banner meeting. Let each one try to help it along.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### REMINISCENCES OF DR. ANDREW W. SMYTH OF SUBCLAVIAN ANEURISM FAME.

By DR. EDMOND SOUCHON, Professor Emeritus Tulane School of Medicine, New Orleans.

The nineteenth century which has just closed presented in New Orleans a number of fine physicians and surgeons, some of which were men of remarkable personality. I remember them much as they were, many of them old men when I was myself a very young man.

Of all these geniuses none was more peculiar, odd and disconcerting than Dr. Andrew W. Smyth who had the signal honor, pluck and luck of curing the first subclavian aneurism of the third portion by the ligation of the large arteries on the proximal side of the sac. No such case had ever been cured before in the world. This startling achievement was the first truly original surgical work ever done in Louisiana. By original work I mean something that had never been done before by any one else. This placed Dr. Smyth on a pedestal where he stood all by himself for many years until another cured aneurism shared his laurels with him.

Dr. Smyth came here as an Irish lad before he was twenty years of age. He first worked in a drug store at the corner of Camp and Poydras Streets. Later on he studied medicine at the New Orleans School of Medicine, a new comer, then located on the site which is now occupied by the Ambulance House of the Charity Hospital. It was an easy school and a cheap one.

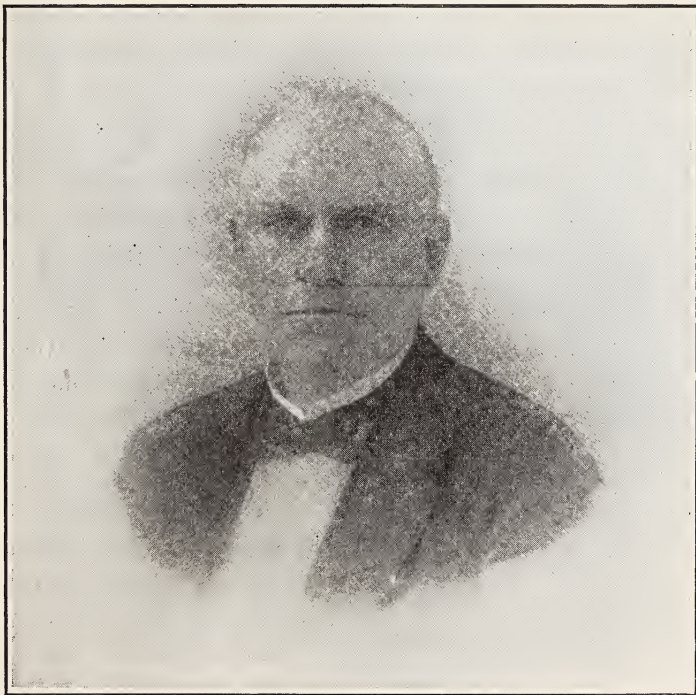
He stammered very much and that made him still more odd. He had a clean shaven face, a bright, piercing, twinkling eye and a slight side smile betokening the Irish strain and wit that were in him. He was of medium height, with large bones, good muscles but very little fat. His hair was rather thin, parted on the side and brushed backwards. His surgical judgment was irregular and uncertain.



He was a great lover of the microscope and when the celebrated London maker, Beck, came to New Orleans, he bought one of his most expensive microscopes, for, I think, one thousand dollars.

With women he was timid and shy. He did not understand them, did not know how to talk to them, how to handle them.

After the Federals took possession of New Orleans in 1863, General Banks put Dr. Smyth in charge of the Charity Hospital.



There he remained for nearly thirteen years, a thorough autocrat of a rather despotic turn, backed by the federal bayonets and the notorious carpetbag governors.

It was in 1864, when 31 years of age, that he performed his famous operation. It was on a mulatto aged thirty-four years, for a right aneurism of the third portion of the subclavian due to efforts made by the patient in catching at an anchor in trying to save himself from drowning in a collision at sea.

The innominate and common carotid were ligated on May 15, 1864. Secondary hemorrhage occurred on about the tenth day.

Ligature of the vertebral was performed and the aneurism closed. The patient left the hospital apparently cured, but still presented a small pulsating tumor about the size of a pigeon's egg. Ten years later he came back with the tumor as large as ever. He had taken to house painting and had used his right arm enormously. The internal mammary was ligated but without benefit. The sac, threatening to burst, was opened with the hope of plugging the opening of the aneurismal artery but in vain. Plugging en masse was effected without avail. The patient died of hemorrhage within forty-eight hours. The autopsy was made by the writer. It showed that the return circulation was due to the anastomosis of the perforating aortic intercostals with the branches of the subscapular in the substance of the great serrate muscle, through which the blood flowed freely through the axillary into the sac. We had thought of these anastomoses as being the principal channels through which the upper extremity was nourished, but it never entered our minds that there was also an upward or retrograde current running back towards the heart. That portion of the axillary artery extending from the origin of the subscapular to the aneurism was carrying a double current, that is a to and fro current. It may be better understood by saying a systolic retrograde current to the aneurism and a diastolic direct current to the arms. The ligature of the axillary between the subscapular and the sac would have cured the case.

The dissection is now in the Army Medical Museum in Washington City. It was not without peculiar and somewhat thrilling incidents that the unique, splendid and invaluable specimen of Dr. Smyth's case landed in our great National Museum.

A few hours after the poor celebrated patient had died, the body was carefully embalmed and with great solicitude injected with cocoa butter and carmine, which gave a most penetrating injection. As soon as ready, I started dissecting it with most intense and anxious interest and with as much celerity as possible because the friends of the dead man were chafing to have the remains to bury them in a style befitting such an illustrious personage. He had no family, but belonged to a colored association whose members were very proud of the great celebrity the man had acquired as they judged from the attention and curiosity which followed him in all his movements.

They were pressing and impatient in their demands for the body and we were giving them all kinds of excuses, hoping to wear out their patience. I for one was doggedly determined that they should not have him without dividing with me, and I wanted the lion's share.

One morning as I was getting through with the dissection, I heard a great row in the waiting room of the dead house. This was then situated on Gravier Street, whereas the entrance to the hospital was in front, of course, on Common Street, a distance of about 300 feet.

I recognized the voice of Dr. Smyth clamoring over the others trying to pacify them again. He had a great deal of influence over them being himself a republican, but this time, I thought his prestige was fast ebbing away and I decided upon a bold *coup d'état* to preserve the to be world-renowned specimen. So I quickly separated the interesting parts from the balance of the corpse, wrapped them up in an old sack cloth that happened to be lying there and passed the package out through a back window to an assistant keeper of the dead-house; telling him to carry it to my coupé which was standing in front of the hospital. I then leaped out through the same window and took the garden-walk opposite to the carrier, that he might not be suspected. I reached the front door of my carriage before him. Taking the much coveted specimen from the carrier and placing it tenderly on the seat next to me I drove off at once to the college, hugging closely my precious and ghastly companion.

After resisting the dead man's friends as long as he could, Dr. Smyth had to yield to them. But judge of their shock and horror when they saw all that was left of their saint, two legs with the viscera and a left arm, without being able to find out where the balance had gone and by what way. I do not think they know it to this day. They had to be contented with what they could get and they made as much of it as if it had been the whole of their friend. Dr. Smyth himself was much surprised and as much at a loss as they but more happily so. He was very glad when he learned where the specimen had gone. It was some satisfaction, he said, to be able to prove that all the arteries he said he had ligated had been really tied.

From the college I moved the specimen to an adjoining building

for fear that the enraged friends might institute a search for him. There he remained, quietly unknown to all but myself in an old whiskey barrel filled with water and alcohol. I could ill afford then to keep him in a finer style, however deserving of it he was. Besides, I did not care to exhibit him much, any way.

After a year or so later Professor Richardson asked me where the famous dissection was. Having told him and what a drain he was on my shallow treasury he asked me if I would not consent to have it sent to the Army Medical Museum in Washington City, to which I gladly consented at once. There I felt sure he would be treated in a manner becoming such a unique relic.

Dr. Richardson and Dr. Groenvelt arranged to have it sent to Washington, where it now rests in peace and security in all its glory in a beautiful all-glass box with a fine crystal lid, bathed over head in pure alcohol, the admiration of all who love subclavian aneurisms of the third portion. I never could get clearly from Dr. Smyth where he had gotten the idea of ligating the vertebral, which procedure cured his case. He rather wished me to believe it was original with him, but the vertebral had been ligated before in such cases by Willard Parker, Bull and Durante, but they all died whereas Dr. Smyth's case survived and that made all the difference. My idea is that he had read about Parker's case.

Besides his bold operation he never performed any operation of any unusual merit. However he was connected with the two following historical cases.

On the day of the fourteenth of September, 1874 General Badger was the commanding officer of the famous Metropolitan Police on which the carpet-baggers placed so much confidence. It was a fine looking force, thoroughly drilled, but rather diffident. It was quickly defeated on that day by the Citizens' League. They fled splendidly before the irresistible charge of the Leaguers. General Badger tried in vain to rally them, but it was of no use. Badger was badly wounded in three places, the elbow, the cheek and the ankle. As he was being carried on a litter to the Charity Hospital I met the litter on the corner of Canal and Bourbon Streets. One of the surrounding White Leaguers in his exasperation raised the butt of his gun to strike Badger on the head. I saw him close his eyes, awaiting the blow, but make not the faintest movement to avert it. A bystander diverted the gun. The litter proceeded



to the hospital and I followed it there. There was Dr. Smyth in a much depressed mood. He at once gave all his attention to Badger. He found that the injury to his ankle was so extensive and so bad that he told the general that he believed that the safest thing to save his life was to amputate his foot. Badger answered in a low and soft voice. "I rather die." Then began a long and strenuous fight against terrible odds.

After two months of suffering and struggle he was well enough to be moved to a cleaner bed. He was much reduced in weight but still of indomitable courage. He was the only one of that Metropolitan Police and notorious carpet-baggers that showed any bravery. Because of his gallantry and courage he was held thereafter in high respect by the community. He lived here many years longer before he died.

Now comes the story of the carpet-bag governor, H. C. Warmoth.

When on a trip in a steam launch Warmoth had his foot caught in the machinery. The great toe was mangled and had to be amputated. Of course it was Dr. Smyth who operated. During the operation one of the bystanders remarked smilingly that Dr. Smyth's hand seemed to tremble. "Yes," said Smyth, "it would not tremble if it was the toe of a low cuss but this is the toe of a governor of Louisiana."

When about middle-aged he became engaged to a sweet, lovely, frail Creole girl. He operated on her for a small tumor of the neck and she died of tetanus. This tragic event profoundly shattered the rugged nature of Dr. Smyth. He would never talk of it even with his closest friends. He was a long time getting over it. However, merciful time did its soothing work. Finally he married and was the father of a handsome daughter, the only child he ever had. No one could ever make out whether or not he was particularly fond of her.

Dr. Smyth was not specially sensitive to hard words. One of the professors in the medical college wished to teach a summer class at the hospital. For the purpose Dr. Smyth had promised him some wards. When the time came to start the class, the professor found out that Dr. Smyth had given them to somebody else. He arraigned Dr. Smyth in very strong, bitter and contemptuous language, ready for a fist fight, but Dr. Smyth took it all in without answering anything.

After leaving the hospital Dr. Smyth opened an office on Canal Street, but he was not much of a success as a practitioner. He did not like it and it did not like him. Dr. Smyth was also at one time, after leaving the hospital, Director of the Mint in New Orleans. During his tenure of office a fire broke out in the vault resulting in some loss to the government, which Dr. Smyth had to make good. But the doctor had not the means and his bondsmen had to pay the damage, which dampened greatly his prestige among them.

He was always very friendly to me. He had a high regard for my french training. He threw several remunerative cases in my way, among others a professional call of four days to Texas, for which I received a fee of twenty-five hundred dollars, the largest fee I ever received. In Texas it was considered a very high fee, but at the time there still lived in Texas a number of the early settlers who continued to believe that a dollar was as large as the moon.

When about sixty years of age the call of the wild was so strong that he returned to the old country on the old family farm on which he was born. It was a dreary life for his American wife and daughter to live in such uncongenial surroundings, in that bleak and harsh country, but his innate egotism did not stop at that. They had to stay with him, wait on him and keep him company. I think only once did they ever come to America in the twenty odd years they lived in Ireland.

Dr. Smyth recently died there at the age of eighty-five. His full name was Andrew Wood Smyth.

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## A GOSPEL OF ERROR.

By C. EDMUND KELLS, D. D. S.

“Experience is by industry achieved  
And perfected by the swift course of time.”

For a layman to use incorrect terms when speaking upon a scientific subject, may be excusable and possibly prove of little moment; but for a professional man to use not only incorrect, but also misleading terms *when referring to his own specialty*, is not only most unfortunate and very reprehensible, but also most astonishing.

This condition unhappily applied to the dental profession as a whole up to very recently, and still applies at the present moment to the whole profession *excepting a very few of its most conservative members.*

*Dead Teeth.* Once upon a time—years ago—some dentist spoke of a pulpless tooth as a “dead tooth,” and *dead teeth* we have been hearing about ever since. Probably not a single dentist has called a *pulpless* tooth anything but a dead tooth up to a very recent date.

Hearing pulpless teeth constantly diagnosed by *dentists* as “dead teeth,” it was perfectly natural for physicians to assume that *they* the dentists, knew what they were talking about, and to reason from analogy that if a tooth were *dead*, it was in reality a foreign body, and consequently harmful and, therefore, should be removed.

Many dentists, themselves, either through ignorance or thoughtlessness, have allowed themselves to become inoculated with this idea, and have joined these physicians in this riot of destruction. They call themselves one hundred per cent vital men. They organize, I believe, one hundred per cent vital clubs. They even go so far as to say that teeth are not necessary to the well being of a human being any way; that people have lived for from twenty to thirty years with no teeth, not even artificial teeth, and have gotten along perfectly well without them.

Just think how they are advertising from the housetops, as it were, their ignorance of the anatomy of a tooth. It is a well known fact that a tooth has two sources of vitality and nourishment—the one through the pulp, the other through the peridental membrane. When, therefore, the pulp, only, dies, the tooth is neither dead nor has it become a foreign body, for it is still alive and receiving its nourishment through the peridental membrane.

Therefore it is that this term *dead tooth*, when referring to a tooth without a pulp, *must* be absolutely eliminated from the vocabulary of both dentist and physician. The use of this term may have been permissible in times past when it caused no evil consequences, but now its use is a *clear confession of grave ignorance*, and ignorance upon a most vital subject. Let us, therefore, blaze it upon the walls that all “who run may read” that as long as a tooth receives nourishment through its peridental membrane, it is not a *dead tooth*, and the mere loss of the pulp, *per se*, is no reason for its extraction.

*The Pulpless Tooth.* The writer has practiced dentistry for over forty years, and during all of that time his greatest ambition has been to save teeth. With this life's work behind him, he cannot be otherwise than distressed to witness the wholesale desecration of the human mouth that is going on to-day. And the most unfortunate feature is the fact that men in the highest position of medical authority are taking dental skiagraphs, and upon the strength of these pictures, are diagnosing some teeth as infected, and advising their extraction.

Upon several occasions during the past year patients have brought me their diagnostic cards from one of the greatest clinics in the land, appealing to me for relief. Upon these cards certain teeth were marked "infected" and extraction advised, and in all instances the patients rebelled against losing what they considered were good teeth. And strange to say, in every case I advised retaining the teeth—*some of which I thought were vital!* Only recently a man in perfect health showed me his card—twelve teeth to be removed, while I am sure no *good dentist* would have been willing to extract any. It certainly was a source of gratification to me to have every one of these patients say that my conclusions would be considered final, and the advice given, to retain the teeth, followed.

Physicians should know that "the people" will not go without teeth; that if their natural teeth are extracted, they will have plates or bridges inserted; that bridges are *usually* carried upon pulpless teeth, or if teeth with vital pulps are crowned, many of these pulps will die under the crowns; that, as a matter of fact, artificial teeth have nothing in their favor except as substitutes for teeth that cannot be saved. Therefore, physicians should never advise the extraction of teeth, but always refer their patients to dentists for a dental diagnosis.

*Infection.* It is a well known fact that infection in the tonsils can be taken up by the blood stream, carried to some distant joint—the knee for example—where the organisms preempt a home-stead; and trouble is the result. Removal of the tonsils causes the removal of the focus of infection and the knee joint goes back to normal. Now the joint between the tooth root and its surrounding alveolar wall is just as much of a joint as is the knee joint. Tell us, then, why organisms, taken up by the blood stream from the



infected tonsil, cannot take up their domain at the end of a healthy pulpless tooth, and produce a "radiolucent area?" In that case, this would be the secondary, and not primary focus. And then, upon the removal of the tonsils, why cannot this secondary infection be cleared up by the circulation and the parts be restored to normal? Is, or is not, that worth considering?

*Abscesses.* The American Medical Dictionary defines an abscess as "a localized collection of pus in a cavity formed by disintegration of tissue."

There's not a dentist of any standing who can but say that he has absolutely *cured alveolar abscesses*, and can show such cases that have stood for years after having been cured. I, myself, can now show such teeth cured of acute abscesses over thirty-five years ago; the teeth in good condition, and the patients in splendid health to-day. Every dentist who has practiced long enough can undoubtedly do the same. And yet, in the face of such incontrovertible evidence, *some* dentists and many physicians, radiodontists and roentgenologists are ordering teeth, which they *think* are abscessed, to be extracted.

*Radiolucent Areas.* There's one more craze now upon the boards that is fraught with just as much evil as that of the "dead tooth," and that is the *radiolucent area* as shown upon dental films. Given a dental skiagraph showing a radiolucent area at the apex of a root, nearly every *film interpreter*, whether he is radiodontist, roentgenologist, or plain dentist, will point to this area and say "abscess." That's where the craze comes in, and of course it is founded either upon ignorance or a misconception of facts.

Whoever diagnoses off hand such a radiolucent area in a dental skiagraph as an abscess, only discloses his ignorance, because those who are conversant with the subject know that no dental *abscess* can be determined by a skiagraph *alone*. The evidence shown upon the film must be backed up by a careful and thorough examination of the mouth, and none but a dentist is capable of doing that.

*To Summarize.* 1. A tooth with a devitalized pulp *is not dead*; it continues to be a *vital tooth* just so long as it receives nourishment from its peridental membrane.

2. Alveolar abscess can be cured just as pneumonia or measles can be cured.

3. Teeth are a valuable asset; are necessary for mastication and from a cosmetic point of view.

4. A radiolucent area may be infected—it may be sterile.
5. Infection cannot be determined by the X-ray.
6. No one but a dentist should advise the extraction of a tooth.
7. It is true that “wonderful cures” have resulted from the extraction of *some* diseased teeth, but what of the countless thousands of good teeth extracted with no beneficial results following?

Such being the facts in this “GOSPEL OF ERROR,” the thoughtful physician who has the welfare of his patients at heart, will yet come to see that in order to render them the best services possible, he must refer them to a dentist, and none other, for an oral diagnosis.\*

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### ADDRESS.\*\*

By HON. A. J. McSHANE, Mayor of New Orleans.

Mr. President, Ladies and Gentlemen:

Members of the Orleans Parish Medical Society, I thank you sincerely for the great honor conferred upon me in selecting me annual orator of your society.

I do not believe, unless I had an official title, that any one would credit me with being an orator but when I get up to speak before any other body I will always feel that I have the endorsement of this highly intellectual and cultured body which gave me the certificate which proves conclusively that I am an orator.

I want to say, for the members of this society, that the health of a community is of paramount importance and that you gentlemen and ladies are the people that this community has always looked up to, to protect and preserve their health. I have lived here all my life, witnessing the many health crises which have faced our community, and you have never been found wanting when you have been called upon.

I believe that this, the new administration, has already shown that they believe in the protection of the health of this community and in the proper administration of medical and sanitary laws which are necessary for such protection, by selecting from amongst you, our health officer—Dr. John Callan. I can say this for him

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\* To those interested in this subject, “THE CRIME OF AGE” in the *Journal of the National Dental Association*, March 1920, might be worth reading.

\*\* Delivered before the Orleans Parish Medical Society, Jan. 10, 1921.

(as I have known him all my life), that the Administration of the Health Department of this City is going to be successful if no other department of this city is successful. Dr. John Callan is not only a medical man but he is a practical man. He has a mind of his own and is going to give service to the people, and I know from my own personal knowledge that if we do nothing else during our administration we deserve the approbation and approval of this community in our selection, for Health Officer, of Dr. John Callan.

I do not know much about medical affairs. My knowledge is only general as to the services that have been rendered and ought to be rendered our community by you gentlemen, but I would ask you tonight (even though I do not believe it is necessary for me to make the request) for your cooperation and help, not only as medical men but as citizens of our community to aid and assist me and my administration in trying to run the affairs, which are yours as well as mine, in a satisfactory manner or at least in a manner which will be as satisfactory as it is possible for such a difficult job as we have before us.

In asking for your cooperation and help I want to call your attention (though again I hardly believe it is necessary), to the condition that we find our city in. I believe this is before your eyes daily. The task that faces this administration is a great one. Our streets are in a terrible condition and as you know, in 1921 we have no paving contract therefore there will be no paving of any consequence put through in 1921. The best we can hope to do is to use all the money and force and energy to repair and put the city into as passable condition as it is possible for us to do.

The finances of this city are in a shape, beginning with 1921, of which I did not come prepared to tell you tonight because I did not get the exact figures, but I want to say to you that the finances are more disappointing to me than I had expected. At some later date you will know exactly how things stand because I have always had the habit of playing the game of life "in the open" and I intend to put my cards on the table that you may see for yourself.

There is one big problem that I would like to mention to you, to-night, and ask your aid, as medical men, in solving;—that is, the problem of "Garbage." The matter of collecting the garbage of this city is important. I, after travelling in practically every

big city in the United States, have observed that we have no system to speak of. It is a problem that has to be solved and must be solved properly and permanently. Each of you can assist us by your advice and it is my belief that you gentlemen, when called on, will do what you can to serve our city.

I greatly appreciate the honor conferred upon me by being permitted to come before your body and speak to medical men. You mean so much in the lives of our people. You bring us into this world and you are at our bedside when we pass out.

Speaking of hard jobs, my observation of the practicing physician is that he has a harder job than encountered in any line of profession or endeavor. He knows no hours of work. He is not a "union man." He works twenty-four hours out of twenty-four and he does not know, when he goes to bed at night just how long he will remain there. I am saying this to show the appreciation that should be shown by a community for the medical men, men who work the greater part of their time for charity. They work among the poor and lowly and do not ask reward.

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## ADDRESS OF THE INCOMING PRESIDENT.\*

By DR. S. M. BLACKSHEAR

It has always been a pleasure for me to be present at these Installation Meetings of our Society but this is a special pleasure since we have with us so many of the fair sex and the Honored Guest—Hon. Mayor McShane.

A few days ago I received a notice advising me of the date of this meeting, and, on glancing over it I came across the alarming announcement that the incoming president was to make an address. "Somebody is always taking the joy out of life". This reminds me of a story I once heard. "A man lost his wife and, after the funeral celebration, and everybody was being assigned to carriages bound for the graveyard, he was told, by the undertaker, that he was to ride in the carriage with his mother-in-law. Well, he said, I will do it, but I want to say you have spoiled the pleasure of the entire occasion for me".

Since the Orleans Parish Medical Society is essentially a Post-Graduate School of Medicine, it is going to be my pleasure to work

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\* Read before the Orleans Parish Medical Society, Jan. 10, 1921.



in conjunction with our Committee on Scientific Essays and endeavor to get more of the big men of the Society to read papers before the Society, for it is from them that we will learn most. We want them to have ample time to prepare their subjects, in order to give them due thought and consideration. And I feel that by this means we can make our scientific meetings so interesting and instructive that every doctor will feel that he cannot afford to miss any one of them.

I wish to take this opportunity to congratulate our new President of the City Board of Health, Dr. John Callan, upon his fight against smallpox, and the progress made toward obtaining universal vaccination, especially since he came before this body and asked our co-operation, stating that it was his interest in organized medicine that led to his accepting this honored position. We want to assure him that he will have our hearty co-operation and we will do everything we can to help him educate the public in regard to health affairs.

Shakespeare said "Brevity is the soul of wit" and I refuse to go too far, but, at the expense of brevity I wish to take this opportunity to thank the Orleans Parish Medical Society for the honor bestowed upon me and to assure each and every member of my last effort toward forwarding the ends of this organization.

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### ADDRESS OF THE RETIRING PRESIDENT.\*

By DR. H. E. BERNADAS.

"The moving finger writes,  
And having writ, moves on",

Omar has said, and I believe this will find echo in the hearts of the shades of Turpin and his staunch believers in the future of Organized Medicine.

One-hundred and sixty years after the founding of New Orleans by Bienville, these believers in a Medical future for New Orleans, where co-ordination and co-operation amongst the Profession would be paramount, banded together to form our Medical Society. Founded upon the rocks of insecurity, its life tenure was always uncertain and frequently tempestuous. To these hardy believers

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\* Read before the Orleans Parish Medical Society, Jan. 10, 1921.

the message of the moving finger, as transcribed to-day, would be a great source of gratification.

The Society, after having buffets and storms has to-day reached the pinnacle of success. From this little band of a dozen believers it has climbed over the four-hundred mark, well on its way to the five-hundred. It has cleared its financial worries and to-day stands independent of any future financial travail,—with a library richly endowed in material and funds,—a library which bids fair to vie with any other in the United States, having as its manager a trained librarian, bringing every inducement and facility to the medical public for research.

A few years ago, had I presented to you, as subject matter, the topic of my report tonight, you would have stated, with the skepticism of the Irishman on beholding the giraffe: "There aint no such animal." However, it is my pleasant duty to introduce to you just such an animal—a rich medical society: The Orleans Parish Medical Society, with \$36,467.55 in funds and \$17,760.00 in property values, making a respectable total of over \$54,000.00.

These results have been accomplished by dint of hard work from many sources. The Elks Domicile Committee and the Special Library Committee have given their efforts in addition to their mental energy toward making this a realization.

The nucleus fund donated by our Society from the Elks Domicile fund was \$5,000.00. This has subsequently been added to from the Society's fund and from the accrued interest it passed the \$6,000.00 mark. It having come to the notice of the Chair that future donations are forthcoming from outside sources, the Chair feels that at least one of his predictions has come true: "The society will one day be proud of its Library.

*Membership.* The membership of the Society on January 1st, 1919, was 339. On January 1st, 1920 it was 408. On January 1st, 1921, it was 430. Associate memberships have risen from 15 to 23.

This rise in membership has been a healthy normal increase due to an improved general tone in the society's affairs, but, more than this, to the fact that the efforts of the Scientific Essays Committee have resulted in a higher par in the material presented, both quantitatively and qualitatively. It gives me pleasure, here, to thank the Chairman of the Scientific Essays Committee, for their efforts during this time.

I pause here to make comment that this and not the American Medical Association's Convention in 1920, was the cause of the increased membership, as by glancing over the report and noting the figures you will observe that the increase in membership (72) was greater in 1919 than in 1920, in spite of the fact that there was no American Medical Association Convention here in 1919. The increase in 1920 was only 18 so that the much vaunted A. M. A. increase cannot be more than this eighteen.

*Funds.* The Orleans Parish Medical Society closes its 1920 Session with the following values in hand:

Funds in Cash and Bonds .....	\$36,476.55
Furnishings and fixtures .....	700.00
Library in 1919 .....	15,000.00
Added fixtures, cataloging, new books.....	2,060.00
	<hr/>
Total.....	\$54,227.55

The funds are as follows:

Balance of \$5,000.00 Library Fund.....	\$ 3,674.15
Added by this administration from its G. F. . .	1,000.00
Additional Liberty Bonds purchased by this ad- ministration from its General Fund.....	500.00
Additional Liberty Bonds purchased from in- terest accrued from Liberty Bonds.....	600.00
Balance in checking account..Jan. 10, 1921..	699.87
Relief Fund.....	88.29
Petty Cash on hand January 1st, 1921.....	15.33
Liberty Bonds.....	30,000.00
	<hr/>
Total.....	\$36,467.55

NOTE. This Society completed its Session with \$2,303.49 in the checking account. On advice of the President the Board voted that \$1,000.00 be added to the Library Fund and \$500.00 be used to purchase additional Liberty Bonds, to be placed with the \$30,600.00 now in trusteeship with the Marine Bank & Trust Company, this arrangement leaving a checking account balance of \$699.87, Relief Fund \$88.29, Petty cash \$15.33, Total \$803.49.

*Deaths.* During the year 1920, the Grim Reaper, with his usual disregard for rank or station in life, has removed from our midst men whose values can hardly be replaced.

Dr. Isadore Dyer, Dr. E. A. Robin, Dr. J. J. D'Aquin, and Dr. Domingo Bornio, have gone to the realms of rest and reward. Their presence and support will henceforth always be a source of loss of the Society. The incentive given by their example in constancy and loyalty to the cause of Organized Medicine stands as a memorial to them. May they stand enshrined in the memory of our Society as workers whose labors have ceased but whose devotion to Medicine will live forever as a glittering example.

*Tulane University.* The Chair here expresses again the gratitude of the society toward Tulane University for having made possible even if only temporarily, the bringing together of all medical efforts under one roof. We now have co-operating under the same roof, the Tulane Medical College, the Louisiana State Medical Society, the Louisiana State Board of Medical Examiners, and the Orleans Parish Medical Society.

This is the fruition of long and earnest efforts on the part of our Society. This has been made possible to a large extent, by the working of Dr. Isadore Dyer whose death we have just mourned.

The medical life of New Orleans is more firmly bound together to-day than ever before in its history and I wish to express the hope that this is only the foundation of a large and more beautiful structure in the future.

*Thanks.* I wish here to thank the Board of Directors, for their support and confidence during the past year. Through their efforts and unstinted assistance the society has reached its present pinnacle. It will be the source of constant pleasure to the Chair, in years to come, to remember with fondest memories, our hours of labor and effort, and because of these, the personal feeling of friendship which has arisen with each individual amongst them, can never be marred or lessened by any subsequent event.

*The Elks Domicile Committee,* headed by its Chairman has spread around its efforts a halo of merit which rests more permanently in the minds of the membership than were it inscribed on a column of marble.

*The Isolation Hospital Committee,* whose distasteful task was so brilliantly concluded, deserves from the Society, a permanent vote of thanks.

*The Narcotic Committee,* whose work is uncompleted, has possibilities far greater than our present "ken" and the Chair wishes them success and thanks them for their efforts to date.



It would hardly be proper to stop this report without thanking, for their constancy, assiduity and whole-hearted devotion to the affairs of the society, the office staff whose work has made possible the brilliant results accomplished by our faithful and altruistic Treasurer and our patient hard-working Secretary. To these gentlemen I extend my personal thanks and those of the Society. Their work will always be a tribute to their devotion to the Orleans Parish Medical Society. The society owes them a debt which cannot be repaid by thanks. They have been the watch-dogs whose functions it was to keep the finances and the business of the Society up to its present high standard and I stop here to thank you individually, Mr. Secretary and Mr. Treasurer.

*Incoming President.* To the incoming president I recommend an increase in insurance to protect our library as its value enhances, so that in the event of loss by fire the society will be appropriately compensated.

As the man who will have to shoulder the burdens of the Society during the coming year I recommend to him the gaining of the confidence of his Board and thereby assure for himself co-operation and mutual understanding. With these assured he will gain success as "a house divided against itself must fall." I state this now because it is my firm belief that the success of this administration has been due to co-operation and mutual understanding.

I wish him the success which I feel he so ardently desires and hope that at the termination of his period of office this Society will say to him. "Well done." In conclusion I wish him the wishes he wishes and the wishes you wish that he wishes, and the wishes I wish that you wish he would wish, and that his success will be so great that to conclude Omar's chant:

"Not all thy piety nor wit will lure it back,  
To cancel half a line,  
Nor all thy tears to wash out a word of it".

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## THE CLASSIFICATION OF RALES\*

By J. BIRNEY GUTHRIE, Professor of Clinical Medicine, Tulane University of Louisiana.

Lt.-Col. Medical Section U. S. A., New Orleans.

The classification of rales is a subject that has claimed the writer's attention as a teacher of physical diagnosis for many years. He looks back on the difficulties he encountered as a student and since then as a teacher. Apparently these difficulties were the result of a varying terminology. The variation apparently has its origin in the freedom in the matter of nomenclature which the various teachers and authors exercised since the time of Laennec. Nearly every author writing on the subject of auscultation has seen fit to change the previously existing classification with the idea of improvement. However, the changes in this perfectly natural evolution were not always in the nature of improvement, as the author believes he will be able to show.

It is quite desirable that the student come into contact with men who have themselves been taught in different schools. This gives the student a little broader grasp of his subject than he would get otherwise. However, in respect to this part of the nomenclature of physical diagnosis, the difference in teachers may bring confusion to the student.

Seldom do we find two authors whose classification is the same. Every writer has apparently been conscious of the difficulty and has tried to make a classification which will clarify the situation. They have all failed to do this. My own effort may meet with the same failure; but, if calling attention to the difficulty may result in some sort of co-ordinated effort to remove obstacles for the medical students, I shall be content.

He may then be spared the supreme memory effort of mastering such a list as the following, taken from the authors I have had at hand: Dry, moist, sonorous, sibilant, mucous, submucous, crepitant, subcrepitant, wheezing, whooping, mucous click, crowing, whistling, piping, squeaking, hissing, humming, high-pitched crackling, bubbling, small bubbling, gurgling, snapping, musical, coarse, fine, resonant, non-resonant, consonating, non-consonating, flapping, cardio-pneumatic, laryngeal, tracheal, cavernous, euphonic, pleural, vesicular, latent, crumpling, crackling, metallic groaning, hollow, metallic tinkling, (*gutta cadens*), bronchopul-

\* Read before Orleans Parish Medical Society, Jan. 24, 1921.

monary, fistula rale, crepitous, indeterminate, *frémissement cataire*, hippocrates succussion. Our first classification came from Laennec, as we all are aware, and it is to-day superior to the classifications found in most of the text-books. He did not use the word rale; but the French word rhonchus. I quote from the translation by Forbes (1),—Rhonchi (Rales).

1. Moist crepittous rhonchus or crepitation.
2. Mucous rhonchus or *gurgling*

}	very large
}	large
}	middling
}	small
3. Dry sonorous rhonchus or snoring.
4. Dry sibilous rhonchus or whistling.
5. Dry crepitous rhonchus, with large bubbles, or crackling.

Those who came after Laennec in their effort to supplement and clarify the work of the master have gone further and produced the almost Rabelaisian collection I have mentioned above. Professor G. Andral in his notes on the 4th and latest French edition of Laennec has the following to say regarding rhonchi (rales): "Since Laennec hardly anything has been added to the excellent description given by him of the different rhonchi."

Surely it is commendable that study of such an important contribution should go on, that a form should be determined and some sort of agreement reached as to terminology to which we shall all agree. It is within the province of constituted medical association to aid in clarifying matters of this kind. It would seem important that medical men who speak the English tongue adopt a standard terminology. The diagnostic value of the signs and the importance of their differentiation is not to be gainsaid. Who will deny that the determination of a different type of rale speaks for a difference in pathology? Yet how frequent is it that we read in medical papers,—“Rales were found at the base.” The writers, who write thus, evidently are choosing a word which all understand and they prefer not to enter a discussion as to classification. Perhaps they are wise.

In a survey of the literature, we find two tendencies. One school among which Austin Flint (2) stands out conspicuously has attempted to establish a nomenclature based on anatomic considera-

tions. Austin Flint's classification is as follows: Laryngeal and tracheal rales; bronchial rales; vesicular rales; cavernous rales; pleural rales; indeterminate rales.

Flint uses the term "so-called" as applied to the subcrepitant rale in the chapter on Classification of Rales and attributes great diagnostic importance to this rale. One gets the impression that he accepts the term against his will. Indeed his idea in departing from Laennec's original classification is set forth on page 140, *loc. cit.* "The term subcrepitant gives rise to confusion and there is no advantage in retaining it as the name of a distinct sign. Very fine bubbling expresses more correctly the characters of the sign. The moist rales are often called mucous rales. The name is obviously inappropriate, since, not only are the sounds produced by other liquids than mucus, but other liquids are best suited for their production, especially in the large and medium sized tubes."

One of the difficulties in classification comes from the limitation of the words "mucous rales." If we take it in the narrow sense of a rale produced by a mucous liquid, all that Flint says is true. However, if we consider the word as applying to a rale produced in a tube lined with mucous membrane, we are justified, perhaps, in preserving it. Flint's subclasses describe vividly the acoustic qualities used by Laennec's *sonorous* and *sibilant*. Yet he avoids the words.

Da Costa the elder (3) uses a strictly anatomic classification: bronchial, vesicular, cavity. His subclasses are made by acoustic qualities and are of the simplest. All of the types of Laennec's main headings are here preserved, namely, *sonorous*, *sibilant*, *mucous*, *crepitant*.

The younger Da Costa (4) puts forth a classification based partly on anatomic and partly on auditory qualities. This is fatal to understand and to good pedagogics. Here, in the writer's opinion, is the source of most of the confusion which exists.

We have another classification which is partly based upon the physical properties of the apparatus producing the sound and partly on the auditory perception of the sound itself.

In explanation of dry rales Sahli says they may have their origin in viscid fluid. This shows how artificial is the term and impossible from the standpoint of clearness. In justification of the term "bubbling," Sahli (5) says: "The term 'bubbling' was em-



ployed because it was formerly supposed that moist rales arose from the bursting of air-bubbles in fluid secretion. Of course, we know now that the contents of the bronchi are not sufficiently fluid for such an explanation; and so we suppose that the rales arise from *membranes of secretion* being formed in the bronchial lumen, and then torn apart again, partly by movement of the air and partly by movement of the lungs." If the term moist does not mean moisture or fluidity of tube content, if a dry rale may have its origin in viscid fluid, are we justified in further burdening medical literature with either of these terms?

Norris and Landis (6) in explanation of a classification purely auditory in character, sonorous, sibilant, crepitant, subcrepitant, bubbling. "Genetically all rales are moist, but sometimes they are classified as 'moist' and 'dry.' These are undesirable terms however, and should not be used. Further the term 'dry' as applied to rales seems paradoxical, for it is impossible to conceive of a 'rale' that does not, to some extent at least, depend on moisture, or increased turgescence for its causation." I heartily agree with this conclusion.

Upon the classification moist or dry, Latham (7) makes this illuminating statement: "Call it *rale* or *rattle* or *crepitation* or what you will; but pray do not add 'mucous' to it by way of specific difference; for this term must always imply that the sound is produced by air passing through mucus, whereas, it is produced equally by air passing through mucus, blood, or any fluid whatever. Besides it is beyond the truth to say that the quality of the fluid through which the air passes can be distinguished by the quality of the sound that results. The sound will indicate the situation and quantity of the fluid and no more."

We are indeed fortunate for this; for most of us believe that the situation and quantity of the fluid may be estimated by the extent and quality of the rales heard after our ears are trained to recognize them. In listening and learning, we must teach our students to see the structure of the region examined and to picture the mechanism of the production of the rale heard, rather than to identify a certain auditory quality for which he must endeavor to find a name. If we insist on an anatomic classification this power will come to the student.

Richard Cabot (8) has departed farthest from the classic nomen-

clature of Laennec. He has done this without utilizing the anatomic classification of Flint. All of the classic terminology has been abandoned with the exception of *crepitant*. Nowhere do we see mention of *mucous*, *subcrepitant*, *sonorous*, or *sibilant*—terms certainly as worthy as *bubbling*, *crackling*, and *musical*. Cabot even mentions “complicated chords from rales which vary in pitch.” One reads and fears that to-morrow may bring forth necessity of adding harmonics to an already full junior year.

Of all the authors cited, Sam J. Gee (9) has, perhaps, adhered more closely to the original of Laennec in the matter of classification. In his foreword, he says: “The sense of words has not been perverted, nor have new words been introduced to denote signs already well denominated. Much of the difficulty of teaching auscultation and percussion to students is due to neglect of these plain rules.” Gee utilizes but four categories,—(1) *crepitant*; (2) *mucous*; (3) *sonorous and sibilant*; (4) *doubtful*.

In starting out to write this paper, I was thoroughly convinced that any departure from the classic terminology was to be deplored. Since examining and tabulating the classifications from various sources, I am convinced that there is no need to sacrifice the advantages of an anatomic classification to this end. If we take three simple heads (1) *crepitant or vesicular*; (2) *mucous or tube*; and (3) *cavernous*, we shall be able to place every rale we hear excepting pleuritic friction sounds which are perhaps best excluded from the category.

It may be that I may be charged with perverting the meaning of the word “*mucous*.” It is surely within a tube lined with mucous membrane that these rales have their origin. Whether fluid or tenacious mucus is the basis of the mechanism which produces them, or whether they are due to turgescence of the lining of the tube, our term applies. We can utilize the classic *subcrepitant*, and the onomatopoeic and classic pair *sonorous* and *sibilant* as subdivisions of the *mucous*. Nearly all of the half a hundred of varieties described by the authors named and others, would be sub-varieties of the *mucous* rale.

Of the other two, one (*crepitant*) stands alone and needs no comment or word of explanation. The other (*cavernous*) I should perhaps include within the category of *mucous* rale also. This would be a further and a desirable simplification. We should then

have but two categories: (1) vesicular or crepitant rales; (2) tube or mucous rales.

The above abridgement involves no departure from Laennec's form other than placing *sonorous* and *sibilant* as subheads of mucous; and the addition of the corresponding anatomic words.

The cavity or cavernous rale could easily be included under the classification of mucous or tube rale, albeit that the place of its production is an expansion or extension of a mucus-lined tube.

In closing the writer asks the teachers of medicine to join him in a discussion of this subject to the end that all may at least adopt a standard terminology. The exact terminology adopted is less important than that all who write on the subject in English may make use of a uniform system which will be understood by all who read.

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#### DISCUSSION.

**Dr. Lemann:** "I quite agree with Dr. Guthrie that the clearer classification, the better classification, from the didactic standpoint is the classification based upon the idea as to where the rale is produced and as to how it is produced. I cannot follow him all the way, however. When the doctor denominates the rales produced in tubes as mucous rales he does so at the risk of giving a false anatomic notion to the student because only the larger bronchi contain mucous glands. Therefore, subcrepitant rales would fall out of this classification.

It might be better to use the Anglo-Saxon terms and call the rales "lung rales" and "tube rales." I am fond of telling my students that no rale is dry. All rales are moist. Dry is a bad term, in my opinion because it misleads the student. If one holds to this conception then we may accept Sahli's explanation of sonorous and sibilant rales; namely, that they are produced by bands of mucus adhering to the walls of the larger bronchi causing local narrowing and hence whistling noises, or lying across the lumen producing a snoring noise. All other rales are produced by a more liquid, less tenacious fluid.

**SOLITARY ABSCESS OF THE KIDNEY.\***

By H. W. E. WALTHER, M. D., F. A. C. S., New Orleans.

Infections of the kidney are broadly classified into two main groups, namely: I. The pyelonephrites, which embraces all infections involving the renal pelvis and adjacent parenchyma; and, II. The cortical septic infarcts of Brewer, so familiar under the caption of focal suppurative nephritis.

The first group of renal lesions still occupy disputed ground as to whether they are of urogenous, lymphogenous or hematogenous origin. Although it is not possible to believe that lesions may be produced by any one of the three factors, the blood-route seems the most possible. The second group however, i. e., the cortical infections, are now universally conceded to be of hematogenous origin.

A. Hyman (*Urol. & Cut. Review*, 1920 xxiv, 11, p. 632) has recently called attention to another type of metastatic renal infection, not generally recognized, the primary focus of which is either a superficial or deep suppurative process not associated with the urinary tract. W. J. Mayo (*Jour. A. M. A.*, 1919, lxxii, 14, p. 1023) alludes to the condition as "hematogenous nephritis." H. H. Young speaks of this type of focal infection of the kidney as being one of the most interesting and puzzling conditions with which urologists have to deal.

The primary focus in this type of case may appear trifling, as for example a furuncle or a carbuncle; or again it may be due to deeply-seated foci as in diseased adnexa.

Metastatic renal abscess differs from the focal suppurative nephritis of Brewer in that in the former abscess is usually single, while in the latter the kidney is invariably found studded with cortical miliary abscesses. Again, in the kidney of Brewer areas of necrosis resembling infarcts are scattered throughout the pyramidal areas, while in the type described by Hyman the rest of the kidney shows no evidence of infection.

The diagnosis of infection of the kidney of metastatic origin is not always easy. Urinalysis often offers little aid, for it is well known that in this type of renal lesion the urine may be found negative, both microscopically and to culture. In such an instance cystoscopy and ureteral catheterism is of value chiefly in determining comparative function of the two kidneys.

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\* Read before Orleans Parish Medical Society, Jan. 24, 1921.



It is practically impossible, in the early stages, to differentiate primary renal abscess from cortical infection or perinephritic abscess. However, the sudden onset of costo-vertebral pain and tenderness, accompanied with fever and chills, and associated with the presence of a history of furuncles or carbuncles or a deep-seated suppurative process in another part of the body should at least make one suspect metastatic renal abscess. Hyman states that the abscess has been observed by him most frequently in the posterior aspect of the kidney, making the tenderness and rigidity most marked in the lumbar region. Should the abscess be located in the anterior aspect of the organ, the symptoms would be more abdominal in character.

The treatment is always surgical. Free lumbar exposure, such as is readily obtained by the Mayo incision, should be practiced. Then decapsulation and delivery of the kidney into the wound where it can be carefully inspected and palpated. Fluctuation can usually be detected, even though the pus be deep-seated. When in doubt, the aspirating needle will decide. Free incision and drainage of the abscess completes the operation. In extensive destruction of the kidney by the suppurative process, nephrectomy may occasionally be necessary but it certainly should be done only in exceptional instances. In cases where nephrotomy alone is done, the prognosis is usually good.

The following case-history of a patient with solitary metastatic abscess of the kidney is of interest. My observations were made through courtesy of Dr. Marion Souchon and I am indebted to him for permission to use the record.

O. M., white male, single, age 26, was admitted to a surgical service at Hotel Dieu on Nov. 10, 1920, complaining of severe pain in the left side and persisting high temperature.

The family history was irrelevant.

Past History. Had usual diseases of childhood. No operations. Had received typhoid vaccination twice while in the army, in 1917 and 1918. Four months ago he began suffering with boils and carbuncles which appeared generally over body. On his right arm alone he counted, at one time, forty boils. Scars showing where his family physician had incised the furuncles and carbuncles verified the patient's statements.

Present Illness. The present trouble began two weeks prior to admission to Hotel Dieu and was ushered in with high fever (101-104) and chills. Soon after constipation became marked and patient began having a severe, dull pain in the left upper quadrant of the abdomen anteriorly. The pain radiated down along the route of the left ureter and terminated in the left testis. He had been forced to go to bed. Had

diurnal and nocturnal frequency, dysuria and ardor urinae. His physician at home had been treating him as a case of typhoid. Mild laxatives produced bowel action promptly, but had no effect on the fever. Patient had no appetite, was very restless and could not sleep at night.

Physical examination showed a patient acutely ill, apathetic, with temperature of 103, pulse 130, respiration 28. General physical development good. Heart and lungs negative. Glands not palpable. Reflexes not exaggerated. Teeth in good condition. Tonsils normal.

The muscles of the abdomen on the left side were rigid and pressure over this side elicited intense pain. It was not possible to palpate the kidney due to muscular rigidity. There were no furuncles nor carbuncles on body now. Examination of external genitals, prostate and seminal vesicles was negative. Urinalysis: amber, clear, specific gravity 1026, acid, no albumin, no sugar, no casts, no pus, no blood and no bacteria (either to smear or culture). Wassermann: negative. No malaria plasmodia. Widal: positive (patient had been vaccinated for typhoid in army in 1917-1918).

Cystoscopy revealed a normal bladder and ureteral ostia. Both ureters were easily catheterized with No. 6 F. catheters to kidneys, no obstruction being met with on either side. Normal urine withdrawn from both kidneys, both chemically, microscopically and to culture. Phthalein appeared from both catheters simultaneously in 5 minutes and in a 15 minutes collection the right kidney excreted 15 per cent of the dye while the left kidney excreted only 9 per cent. Pyelograms showed normal pelves and the kidneys in their normal position. No calculi anywhere in urinary tract.

On Nov. 10th total white count of blood was 15,800; on Nov. 16th 28,300; and on Nov. 19th 34,100.

A preoperative diagnosis of left-sided perinephritic abscess was made. On Nov. 20th under ether anesthesia, Dr. Souchon, assisted by the writer, exposed the left kidney by the usual lumbar incision. To our surprise no perinephritic accumulation of pus could be found. The kidney felt much enlarged, and somewhat adherent. Decapsulation was then done and the kidney delivered into the wound. The enlargement of the organ was marked in its upper pole. Fluctuation could be distinctly felt. The upper pole of the kidney was then incised, in Brodel's line, for about three inches. The first cut did not reveal pus. The incision was then deepened and about a half pint of thick pus was liberated. The pus had been encountered about two inches from the surface of the organ. A cigarette drain was placed in the kidney incision and fixed. Gauze drains placed down to kidney and wound closed by layers around drains. Cultures from pus showed pure strain of streptococcus. Following operation patient made an uneventful recovery.

That streptococci should have been found in the renal abscess would argue against furunculosis as the causative factor in this case. However it is possible that the renal lesion might have been originally a staphylococcus infection and that the streptococci were secondary invaders. Or again, the streptococci may have entered the circulation via the carbuncles. Be that as it may, I cannot but

feel that the skin infections were the primary factors in causing the abscess in the kidney.

From clinical observations made on this case and from a careful study of literature relative to this interesting condition, the following conclusions are submitted.

#### CONCLUSIONS.

I. In cases suffering with persistent high fever and prostration, with symptoms referable to the kidney, and with a history of furuncle or carbuncle, even with a negative urinalysis, metastatic abscess of the kidney should be considered.

II. Unless improvement evidences itself within a reasonable time, by employment of the usual expectant methods, surgical intervention should be resorted to.

III. Nephrotomy and drainage should be the procedure of choice. Nephrectomy only to be employed in exceptional instances where renal destruction has advanced to such a stage as to preclude saving the organ.

#### DISCUSSION.

**Dr. Kahle.** Dr. Walther is to be congratulated on his excellent paper, and, I shall endeavor to emphasize some points which I am sure Dr. Walther would have brought out, if he had had more time. I shall also discuss some points, which seem to me to deserve attention. In the first place the title of the paper, *Metastatic Abscess of the Kidney*, gives an impression which is not correct. It would imply that metastatic renal infections are rare, when as a matter of fact, the vast majority of all renal infections are metastatic, whether the metastasis takes place via the hematogenous or via the lymphatic route. It may be that the infection is carried to the blood stream by the lymphatic, but by whichever route the kidneys are reached, the infection is metastatic. It is only very exceptionally that the kidneys are infected by bacterial irruption from neighboring organs, and, although we can conceive of and do see such cases, they are very exceptional. In Dr. Walther's case, where the infection was preceded by a furunculosis, there can be no doubt that the kidneys were subjected to massive doses of bacteria brought by the blood stream, and, that one of them at least, was overwhelmed with resultant suppuration. That the kidneys are not infrequently subjected to these massive doses of bacteria, without discoverable damage to them, can not be doubted. We often see cases of bacteriurias, in which we find nothing but the bacteria, with no pus, red blood cells, or any other pathological elements, which would indicate damage to the kidney. In such cases, which have subsequently come to the post mortem table, no infection of the kidney could be demonstrated. In other words, that bacteria can be secreted by the kidneys, when no renal disease can be demonstrated, is a fact which we often observe. This holds good for tubercular bacilli, as well as the pyogenic bacteria. It may be hard



to conceive that normal, healthy renal epithelium would secrete bacteria but even if we admit that this takes place only where the epithelial cells are diseased, we are unable to prove that they are by our present methods of diagnosis. This brings up to my mind the common practice of some of our hospital laboratories, of depending entirely on cultures for diagnosis, giving no particular attention, if any, to the presence of pathological elements in the urine. Such methods lead to errors both ways—a diseased condition will be reported where none exists, or as in cases of hyperacute focal suppurative nephritis, such as I believe Dr. Walther's case to be, where in about five per cent of cases, no bacteria are to be found, the report will lead to serious delays, or incorrect diagnosis, which may result in an operation for a cholecystitis or for appendicitis, much to the humiliation of the surgeon and worse still, to the safety of the patient. In view of these not infrequent bacteriurias, urologists, I believe, are fairly well agreed that renal infections are dependent probably less on the bacteria that reach the kidney, than on the accessory causes, such as trauma—operative or external, as a result of blows or wrenches in which the kidney would be squeezed in the costo-vertical angle; whether due to calculi; to toxemias; to retention; the results of nephroptosis, strictures of the ureter, pelvic tumors, distortions of the ureter, due to pelvic inflammation or proci-dentia, to tumors of the ureter or what not?

In Dr. Walther's case the patient had been given typhoid vaccine, some time previous to his present condition. It may be that the toxemia resulting, may have had some bearing on the present condition, but as both kidneys were evidently affected to the same degree by the toxemia, there must have been some other accessory cause, which would result in greater damage to one kidney than to the other. The fact that this accessory cause was not or could not be determined does not to my mind, alter the assumption of its presence, since it is not unreasonable to assume that both kidneys were no doubt subjected to the bacterial onslaught in the same proportion following the furunculosis.

The case presented, I believe, was one of hyperacute focal suppurative nephritis, with the abscess, or coalescing abscesses, in one of the cortical columns, a column of Bertini. I am inclined to believe this because of the fact that the infection was due to cocci and cocci are secreted by the glomeruli instead of the tubules as is the case in infections due to bacilli of the colon type. This fact explains the absence of urinary findings as the cocci reach the calices and the pelvis of the kidney only late, if at all. It is this fact, that at times makes the diagnosis difficult and leads to errors. The patient has chills, temperature, a high blood count, pain in the region of the gall-bladder or in the region of the appendix and the urinary findings are negative. Generally, we would be prone to exclude the kidney under such circumstances. The cystoscopic examination with catheterization of the ureters would give no more information and would only tend to confirm the fact that the kidney was not at fault, however, if a functional test were done, the key to the whole situation would be gotten, because the marked decrease of function in the diseased side would clear the diagnosis. From this, and the fact that by ballottement of the kidney, we can elicit pain, we may state that the diseased function and ballottement may be the only but certainly the most reliable data on which to base our diagnosis of a hyperacute focal suppurative nephritis.



In Dr. Walther's case there are two symptoms, which to my mind are a little unusual. First, the muscular rigidity and second the frequency of urination. The rigidity I would expect to find in the presence of some perinephritic exudate. The frequency, only if there were involvement of the pelvis of the kidney or of the ureter, which certainly was not the case here. In my experience an irritation or inflammation of the pelvis often reflexly manifests itself by frequency. Intra-capsular pressure does not.

In cases of this type the only relief is surgical and I believe that often the judgment of the surgeon is taxed as to the best procedure to follow. The patient's general condition, permitting, and the opposite kidney showing a good functional capacity, even in the presence of a mild pyelonephritis, which is not frequently present and depending on the focus in the bad kidney, a nephrectomy should be done. If because of the general condition or because of a kidney whose function is low and which no doubt is incapable of taking on an extra load, we may resort to a nephrostomy or to a nephrotriesis, waiting until the patient has overcome his sepsis and the general health has returned before doing the nephrectomy or subcapsular nephrectomy, as the case may be. By this time the opposite kidney has fully compensated and it may even happen, and it does happen, that the diseased kidney has come back. Under these circumstances it may be allowed to remain. This two stage operation does not only apply in cases of hyperacute focal suppurative nephritis but should be done in cases showing marked sepsis whether due to infected calculi or to other renal infections. It should certainly be done in cases in which full compensation has not been attained in the opposite kidney or in the presence of a diseased condition. It is the safest method in difficult cases or septic cases in which shock and a prolonged anesthetic would militate against the patient's safety.

**Dr. Lemann.** There is a phase of infection of the kidney through the blood to which Dr. Walther alluded which should interest the profession at large; namely, the frequency of nephritis due to focal infection.

I do not feel that I am wandering from the discussion in referring to this point because it is merely a matter of accident whether there would result truly an abscess following the original infection or merely a nephritis.

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Dr. F. de P. Miranda, of the Mexican National Board of Health, gave a resumé of the most important facts concerning the knowledge of the causative agent of Yellow Fever—*Leptospira ichterooides*, before the Orleans Parish Medical Society at its regular Scientific Meeting, January 24th, 1921.

This culture was cultivated by Dr. Perez Grovas, in Vera Cruz, from guinea pigs injected with blood taken from yellow fever patients. The culture was carried to Mexico City and has been transplanted several times and is of the same stock as that now used for preparations of vaccines being used in Vera Cruz. Dr. Miranda was sent here by the Mexican National Board of Health to follow

the plague campaign and to do some Post-Graduate studies in Tropical Diseases and Sanitation. Dr. Miranda is matriculated in the Graduate School of Medicine, Tulane University. He will remain in our city until June, 1921.

Dr. Perez Grovas, of the Bacteriological Institute of Mexico, Mexico City, isolated the organism in Vera Cruz, confirming the work of Dr. Noguchi of the Rockefeller Institute.

Dr. Miranda's demonstration was discussed by Dr. W. H. Seemann, Dr. J. B. Guthrie, Dr. H. P. Jones, Dr. O. L. Pothier and Dr. Maurice Couret.

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## ANNUAL REPORT OF TREASURER OF THE ORLEANS PARISH MEDICAL SOCIETY FOR 1920.\*

By F. M. JOHNS, M. D.

December 30, 1920.

### GENERAL FUND.

Actual cash receipts for 1920.....	8,706.95	
Balance from 1919.....	\$ 549.07	
	<hr/>	
Total receipts .....	\$ 9,256.02	
Expenditures 1920 .....	7,153.15	
	<hr/>	
Balance of General Fund.....	\$ 2,102.87	\$ 2,102.87

### PETTY CASH FUND.

Petty cash on hand, Dec. 30, 1920.....	15.33
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### RELIEF FUND.

January 28, 1920 .....	\$ 85.41	
Accrued interest (January to June).....	2.88	
	<hr/>	
Balance .....	\$ 88.29	88.29

### DOMICILE FUND.

Received from Domicile Committee Liberty Bonds (4¼'s) .....		\$30,000.00
Accrued interest .....	\$ 637.50	
Purchase of \$600 worth Liberty Bonds (4¼'s).....	520.19	
Commissions .....	12.75	
	<hr/>	
Balance .....	532.94	600.00
Returned to general fund.....	90.78	
Transferred to Liberty fund.....	13.78	
	<hr/>	
Balance .....		\$51,806.49

## LIBRARY FUND.

Fund created by O. P. M. S. out of Domicile Sale.....	\$ 5,000.00	
Transferred from Bond Interest by Board of Direct.	13.78	
Accrued interest .....	35.00	
		\$ 5,048.78
Expenditures by Librarian and Special Committee	1,235.06	
		\$ 3,813.72
Balance .....		\$51,806.49
Brought Forward .....		
		\$55,620.21

## SCARLET RED EMULSION FOR THE TREATMENT OF OZENA.

By JOHN H. POWELL, M. D. Atlanta, Ga.

I have been very much impressed by results from the use of an Emulsion of Scarlet Red. The principal justification for experimental testing was suggested by Dr. Louis Jacobs, New York, ("The Successful Treatment of Atrophic Rhinitis and Ozena," *New York Medical Journal*, May 31, 1913). According to the author, an Emulsion of Scarlet Red gave a very favorable account of itself in the treatment of chronic nasal conditions.

Realizing the importance of carefully analyzing clinical reports from various sources, based upon close observation, before final conclusions are warranted, feel that it is my duty to offer a report on a series of *twelve* cases of ozena in which the treatment, in part at least, consisted of 4 per cent Scarlet Red Emulsion. The following case histories are representative of the entire series to which I refer:

**Case 1.** Female, age 22, gave history of ozena odor for the past ten years. Typical ozena with atrophy of the nasal mucosa and scab formation. Inferior turbinates atrophied and denuded of mucous membrane in spots, tube-shaped scabs filling roof of nose.

Ethmoiditis, at first, suspected, but after several observations this was ruled out and diagnosis of ozena made. Wassermann—negative.

**Treatment:** The mucous membrane was thoroughly cleaned with alkaline glycerine spray. Patient used this spray at home for several days. Inferior turbinates were removed with scissors, and Scarlet Red Emulsion applied on cotton applicator and rubbed into the mucosa well, going back into the posterior nares, which showed some atrophy. At first treatment was given every other day. In two weeks scabs and odor had disappeared, then treatment was given every third day, and later, once a week, no scabs or odor in the meantime.

Patient was under treatment for two months and showed rapid improvement from the start. At the end of this time the mucosa seemed to be thicker, had a better color, and scab formation and odor had disappeared. Patient advised to return later for observation. After a lapse of six weeks she reported again and inspection of nose showed that some of the symptoms were returning; however, the nose was in far better condition than with any other treatment I have ever used on similar cases.

**Case 2.** Female, age 45; history of digestive disturbances and constipation for a year or more. Patient anaemic and poorly nourished. Typical case of ozena, with odor, no enlargement of turbinates requiring operation.

**Treatment:** Same as in Case 1, for a period of two months; also given tonic and laxative. Improvement noted from first in both local and general condition. Scab formation and odor disappeared and mucosa improved in color and thickness. Patient apparently well.

In some of the cases pieces of turbinate were removed, and in some instances it was necessary to touch ulcerated patches with Silver Nitrate Solution.

In the treatment of any case of ozena, the first thing to consider is that of nasal toilet. Each patient should be instructed to provide means of applying a non-irritating alkaline spray, which should be used at home during the intervals between treatments. Treatments at the office should be insisted upon at least every second or third day for ten days to two weeks.

The mucous membrane should be thoroughly cleaned and all crusts or scab formations removed. Scarlet Red Emulsion is then applied by means of a cotton applicator, exercising care in completely covering all patches with the emulsion, then gently massaging it into the tissues with the cotton applicator, saturated with the medicament.

It is only fair to assume that the cleansing process adopted in these cases materially benefits the average case of chronic rhinitis or ozena, but a careful observation of the end-results seems to justify the conclusion that the Scarlet Red Emulsion when properly applied, exerts a decided influence upon the mucous membrane in stimulating the healthy reproduction of the tissue cells. The addition of a rational tonic treatment for these cases should not be overlooked, in fact the average case of long standing requires some general medication in addition to the local treatment.

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**PROCEEDINGS OF THE STAFF OF TOURO INFIRMARY****(HELD AT TOURO ON FEBRUARY 9, 1921.)**

DR. R. M. VAN WART.—86071. This patient was originally referred by Dr. Eshleman to Dr. Holbrook in May 1920 on account of his mental condition. He showed on examination evidence of mental deterioration with some speech disturbance and defects in calculation. The pupils were irregular and reacted only slightly to light. The patellar reflexes were absent and there was a right hemianopsia. The patient was treated with iodides and mercury but showed no improvement. The light reaction of the pupils disappeared in July. He continued under treatment until August when he stated that he felt much better though there was no improvement in the original findings. In September, he developed an erythema for which he was treated by Dr. Menage and at the same time he was seen by Dr. Eshleman for temperature which developed during the course of his treatment. He was seen again early in November. His skin condition had cleared up but the neurological findings were unchanged. He was then lost sight of until November 21st when he was again seen at home at the request of his relatives who stated that he was quite restless and talked quite incoherently. He was then living alone, was not eating anything and his condition was quite serious. He was admitted to the hospital with the expectation that he would die any time. On November 23rd, he was seen by Dr. Weis who found nothing but a hypostatic condition in the right lung. That night the patient tried to jump out of the window, was more quiet the next day, but was sufficiently clear to give any detailed information or to answer questions. It is interesting to note that he at no time complained of gastric symptoms. He was again agitated on November 26th,—thought somebody was trying to kill him. He continued restless and talkative especially at night with occasional vomiting attacks. His mental condition was not such as to enable us to obtain any accurate information. The hypostatic condition in the left lung continued to increase and he was expected to die at any time. On the night of December 1st, he drank a bottle of coca-cola, shortly after which he became nauseated and vomited material like coffee grounds. He was extremely restless and at midnight he complained of a pain in the abdomen for the first time. His pulse became weak

and forty-five minutes after the onset of the abdominal symptoms he died.

His condition at no time after his entrance to the hospital would have permitted surgical interference. At the autopsy were found two ulcers of the duodenum, one of which had perforated. The case is of interest as showing what unexpected conditions patients may be suffering from and which post-mortem examinations show to be present. In reviewing this case, one cannot see where duodenal ulcer was to have been suspected from the history and complaints of the patient until the terminal symptoms.

At autopsy, the anatomical diagnosis was:

Acute peritonitis

Ulcer of Duodenum with Rupture (Double ulcer)

Cirrhosis of Liver

Chronic Interstitial nephritis

Chronic Splenitis

Chronic Pancreatitis

Edema of the Lung

Edema of the Brain

(Complete examination of the brain has not yet been made.)

DR. A. L. LEVIN. History of case to be discussed. The history of this case, as read by the interne, is very brief and not complete. The patient first came under my observation in January, 1919. Five and one-half years ago, he began to experience off and on a choking sensation and irregular vomiting spells. Appendectomy was performed in 1913. He was relieved for about six months. Then he developed stomach trouble consisting of sour belching, regurgitation, occasionally, no pain, no vomiting, bowels very constive, and some loss of weight. From April, 1918 to September, 1918 he was treated for ulcer; was in bed for 30 days and he was relieved for a while, but not cured. Four months later, he began to suffer from the same symptoms. Habits, tobacco excessively—P. H. Diphtheria ten years ago.

Exam. H. and L. negative. B. P. 120-76

Abd. soft—operative scar—no sensitiveness.

Reflexes normal. Urine negative. Occult blood negative. T. B. Slight hyperacidity.

He complained mainly of constipation and a bad taste in his mouth. I kept him under observation for a while, the symptoms

were not relieved. He left the city and led an irregular and hard life in the country paying very little attention to his diet. He also made a trip to Europe and back. In December, 1920, he returned to me complaining of epigastric pain for the last two weeks which comes on two or three hours after a meal and relieved by food; the pain was gnawing in character. He is not disturbed at night. Suffers from sour belching; bowels tendency to constipation and he lost in weight considerably. About a week previous, he suffered from peritonsillar abscess which was opened.

On examination, I found a very sensitive spot about  $2\frac{1}{2}$  inches above the umbilicus and to the right. I advised an X-ray for the following day and ordered temporarily an alkaline powder and cautioned about diet. That same evening about 7 P. M. after supper, he suddenly developed a very sharp pain in the upper abdomen and difficulty in breathing.

The picture was very characteristic of a perforated ulcer. I examined him about 45 minutes later and noticed the following symptoms:

1. Marked pallor and profound shock, knees tightly flexed on abdomen.
2. Dyspnoea.
3. Very rigid abdomen.
4. Rapid and irregular pulse.
5. No relief from  $\frac{1}{4}$  morphine.

I introduced a Jutte tube carefully and obtained a large quantity of liquid food, evidently from a meal eaten during the day in which could be seen fresh blood.

I diagnosed the case as "Perforated Duodenal Ulcer" and phoned for Dr. Maes; he corroborated the diagnosis of perforated ulcer and immediate surgical intervention was decided upon.

Osler remarks: "As a rule, sub-acute and chronic ulcers of the duodenum tend to persist, and, eventually, will require surgical treatment. It is wiser, therefore, the resort to surgical measures as early as possible in such cases as soon as a diagnosis can be made." This case demonstrates the great value of Osler's dictum.

In January, 1920, there was an article in the *California State Journal of Medicine* by Harlan Shoemaker, in which he analyzed 22 instances of perforated gastric and duodenal ulcers that occurred in the Los Angeles County Hospital from 1916 to 1918.

Six of the patients in this group died, seven of this group had been previously treated medically for ulcer of the stomach or duodenum in the above institution, and discharged as improved or cured, only to rupture. One perforation occurred within one month after leaving the hospital, and the longest quiescent period was two years. Shoemaker points out that after rupture of an ulcer, three phases present themselves: First, the stage of contamination when no infection is present. This stage generally last 10 hours from the onset of the acute pain and is considered the best period for an operation. The second phase occurs after contamination when the patient feels somewhat better. The last stage is that of general peritonitis when the pain recurs and the termination is fatal.

T. Dunham (Trans. Med. Soc. of N. Y. Med. Rec. Apr. 3, 1920), lays stress on early intense rigidity as a diagnostic sign of perforated duodenal ulcer. This is because perforation of the stomach or duodenum causes at first a chemical peritonitis, while lower down in the intestine, there is instead a delayed bacterial peritonitis. The position of the patient and fixed rigidity are striking in these cases.

I also wish to mention a point which was probably in favor of the patient's recovery. It is a well known fact that the introduction of a large stomach tube in such cases is as a rule contraindicated. I carefully introduced a Jutte tube through the nose and emptied the stomach of about 30 ounces of liquid food material mixed with fresh blood, lessening thereby the escape of stomach contents into the peritoneal cavity, and preventing early contamination.

DR. URBAN MAES.—Case 1. Up to 1918 the history of this patient is irrelevant except for an attack of appendicitis for which he was operated on in 1912. His present complaint began in 1918 with pain in the epigastrium. He was treated for gastric ulcer over a period of time and about three weeks after treatment had been discontinued he again suffered from pain in the stomach region and a constant feeling of fullness in the throat. He had pain at irregular intervals up to one week ago when, after eating supper, he was seized with a sudden violent pain in the right upper abdomen. He was seen by Dr. Levin who recognized a perforated gastric ulcer and sent the patient to the hospital. We operated



on him approximately five hours after the perforation occurred and found a clean cut punched out hole on the anterior surface of the first portion of the duodenum. This was closed by a purse string suture and covered with an omental graft. The patient made an uneventful recovery. This is my fourth perforation of gastric or duodenal ulcer, all of which have made good post-operative recoveries and all have remained well up to this time but one. This man was subsequently operated on elsewhere and has remained well. This is in line with the idea that when a peptic ulcer perforates if the patient survives perforation and the surgical intervention the ulcer is usually cured.

In this instance there was some fat necrosis which was treated with Dakin Solution. On the fourth day of Dakinization the wound was pus free, there being no secretion what ever. The patient is about to be discharged.

#### DISCUSSION.

DR. C. JEFF MILLER. In line with the case mentioned by Dr. Maes, I have had three perforated stomach ulcers recently—one happens to be in the house at present. The last case is of interest in that perforation had occurred eleven days before his admission to the hospital. The history was typical and six days after the onset, a sudden distension occurred in the epigastrium and was so circumscribed that it appeared dome-shaped in its contour. The abdomen was opened, quite an amount of gas escaped and more than a pint of pus which had been confined to the lesser peritoneal sac. Nothing was attempted in this case, but drainage and he is making an uneventful recovery.

The question as to whether gastroenterostomy should be done at the same time that the attempt is made to close the perforation is open to discussion. Few men have the temerity to advise gastroenterostomy as a routine in these cases as the condition rarely ever admits of a satisfactory technique and the further risk of contamination. I have only performed a gastroenterostomy in one out of eight cases of perforation. In the other cases, the opening was simply closed and drainage established. Every case occurred in men and the after results have been particularly satisfactory. Ulcers about the pylorus do not rupture as often as ulcers situated at a distance from the pylorus, and, for this reason, gastro-enterostomy is not necessary as a routine measure.

DR. URBAN MAES—(Discussion). In answer to Dr. Miller I would say that stab and gunshot wounds of the upper abdomen are dangerous in direct ratio to the time which has elapsed after eating. I remember one stab wound involving the stomach which occurred some time after eating and the patient made an uneventful recovery without operation. We have seen some perforations with a full stomach, the patient discharging partly digested gastric contents into the peritoneal sac and yet these patients have recovered after operation. In a recent article one surgeon claims that he always performs a gastro-enterostomy in these patients. This should only be done if the patients condition is good. Dr. Miller says that the question of gastro-enterostomy should be decided by the amount of cicatrization at the pylorus. It is my impression that pyloric ulcers with much scarring rarely perforate. The experience of Dr. Martin of Baltimore in a large series of cases showed that practically all of these patients who survived the operation were permanently cured of the ulcer.

DR. MAES—2nd. Case. Since we are showing interesting surgical conditions I think this one is sufficiently interesting. Patient was taken sick at about nine o'clock in the morning with sudden severe abdominal pain. After trying the usual household remedies he summoned help from the Touro and Dr. I. M. Gage answered the call. Dr. Gage made a tentative diagnosis of acute intestinal obstruction. I saw the patient with Dr. Gage and concurred in his opinion. We operated and found a typical Meckel's diverticulum which was not badly diseased but showed one of the characteristic lesions associated with diverticulitis. The diverticulum had become adherent in one of the two characteristic locations, that is through the anterior abdominal wall or to the mesenteric border of the gut. In this instance it had become attached to the latter throwing a band across the bowel with a quarter turn on its axis. The bowel above was enormously dilated and collapsed below. After relieving the constriction the gut looked quite cyanotic and with the discension seemed seriously threatened. I put in a Pezzer catheter after the method which I learned from Dr. Parham and have since found very valuable in relieving acute abdominal conditions. The point I wish to bring out is the textbook picture of a lesion caused by Meckel's diverticulum becoming adherent to the mesenteric border of the gut.

The patient has made an uneventful recovery. The Pezzer catheter was removed on the fourth day and he has had no recurrence of symptoms.

I wish to show another patient but as it is getting late I will merely relate the story. The patient is 76 years old and has a more chronic type of obstruction. The patient became ill about a week ago, his main symptom being a gradually increasing constipation. The physician in attendance had always been able to note some slight result from the use of enemas. There had been no vomiting, no distension and no increase in pulse rate up to the day of admission when these symptoms all became very prominent. From the history I suspected an annular carcinoma of the large intestine, rather high. This was confirmed to-day on X-ray examination and is located at the hepatic flexure. Patient was opened under local anesthesia, the bowel tapped with a Pezzer catheter. The patient has made an uneventful recovery.

DISCUSSION BY DR. F. W. PARHAM: I am much interested in the report and remarks of Dr. Maes regarding enterostomy in intestinal obstruction. In cases where the patient's condition does not permit of an extended search, and, even in cases where the obstruction has been found and relieved, this procedure is often found to be a life-saving measure.

Some years ago, I made a report before the Louisiana State Medical Society in which I recommended this procedure with a Pezzer catheter and, since that time, Dr. Maes and others besides me have had some considerable experience with it in such cases. In some cases, the use of this catheter for temporary drainage by relieving congestion actually seems to overcome the strangulation. In all cases where there is much distension, it may be used with advantage during operation and after operation when this condition supervenes. I believe it is wise to drain the bowel above the obstruction and not turn the contents down into the collapsed bowel which is ready for absorption.

I would like also to speak of a case of obstruction caused by Meckel's Diverticulum in which the young man about 18 years of age, giving a history of repeated attacks of obstruction marked by colicky pains, came into my hands with a very severe attack. I found the obstruction was due to a Meckel's diverticulum with the remains of the omphalo-mesenteric duct running from the

tip of the diverticulum to the umbilicus where it was attached. This cord formed the obstructing band. I cut this cord away, tucked in the diverticulum and there was no further trouble.

DR. ISIDORE COHN—(Discussion). During the past week, we had a case which proved very interesting because it presented symptoms of abdominal disease pointing particularly to the gall-bladder, but the appendix having previously been removed, we were unable to account for the pain which the patient complained of below the umbilicus. Prior to my seeing him, he had been given large doses of morphine and opium pills by an attending physician. The history which I obtained was that of an acute abdominal pain below the umbilicus and equally distributed on both sides. There was an associated nausea and vomiting. Examination revealed the following:

Temperature  $97 \frac{4}{5}$  degrees; pulse 110; there was slight rigidity of the abdominal wall particularly on the right side, most marked under the costal border about the level of the ninth rib. The greatest tenderness was noted at a point mid-way between the anterior superior spine of the ileum and the umbilicus. He was immediately transferred to the hospital and the blood count on admission showed 17,000 total with a differential count of 94% of polynuclears. Tentative diagnosis of "Acute Cholecystitis" was made. Operation was advised and immediately proceeded with. We found evidence of an acute gall-bladder disease; there were adhesions from the fundus of the gall-bladder to the cystic duct; the walls of the gall-bladder were thickened and gray. There were no stones palpable in the gall-bladder, cystic or common ducts. Examination of the stomach revealed no evidence of recent or old ulcer. The pylorus was patent; duodenum presented no abnormality. We then proceeded with a cholecystectomy in the usual way by first ligating the cystic duct and artery and removing from below upward. Because of the intense pain which the patient had complained of below the umbilicus, we sought for a reason of this pain in the region of the appendix and small intestine. After locating the cecum and the ileo-cecal junction, we made a systematic examination of the first portion of the ileum. When we had proceeded about 8 inches from the ileo-cecal junction, we noted that the omentum entirely surrounded a loop of ileum lay free and not adherent to the omentum at any place. This omental ring as a possible cause of ob-



struction and pain was evident. The ring was then incised between clamps, the ends of the omentum ligated and allowed to retract into the abdomen. The ileum was then free. The abdomen was then closed in the usual way. It should be noted that the patient had an appendectomy one year ago. The subsequent course of this case has been uneventful with the exception of slight post-operative nausea. This case is presented because of the unusual nature of cause of obstruction. Whether it is of congenital or of acquired origin, we are not in position to state, but in all probability, it was of congenital origin because the loop of bowel which passed through the omental ring was nowhere adherent to the omentum.

DR. URBAN MAES. I wish to thank Dr. Parham for his remarks and to say that I learned to use this method of enterostomy from him. In answer to the point made by Dr. Parham that the absorption is the cause of some of the symptoms, I would say that I question this. We learned some years ago from some experiments by Dr. Gurd that the toxicity is probably due to a split proteid which has its origin in the mucous membrane of the gut. Gurd showed in his experiments that from a loop of gut which has been thoroughly washed he scraped the mucous membrane and after autolysis of this substance under toluol he was able to reproduce symptoms by the injection of this material. The alterations in the mucosa come as a result of changes in the terminal mesenteric circulation. The toxin in turn has a direct effect on the plexus of Auerbach and Meisner causing the paralysis and distension of the gut. The relief of symptoms from the use of the enterostomy is probably mechanical and helps by overcoming the condition just mentioned. We have been able to show this recently in two cases where a partial autopsy was secured. The gut in both instances was so nearly gangrenous at operation that nothing more than the simple enterostomy could be done. In both of these cases the coils adjacent to the area drained by the catheter had fully recovered, but the extension of the process some distance away was the cause of the fatal termination.

(To be continued.)

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**BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.**

By P. T. TALBOT, M. D., Secy-Treas.

*NOTICE*:—In the last issue the printers made an error in publishing the names of Chairmen of Scientific Sections for the approaching meeting of the Louisiana State Medical Society. We desire to especially call your attention to this unavoidable discrepancy and to publish in full the names of the various Chairmen as follows:

*Medicine and Therapeutic Section*, Dr. T. P. Lloyd, Chairman, Shreveport; *Pediatric Section*, Dr. C. J. Bloom, Chairman, New Orleans; *Section on Nervous Diseases*, Dr. J. A. O'Hara, Chairman, New Orleans; *Section on Bacteriology and Pathology*, Dr. O. L. Pothier, Chairman, New Orleans; *Section on Health and Sanitation*, Dr. W. F. Carstens, Chairman, New Iberia; *Surgical Section*, Dr. G. M. G. Stafford, Chairman, Alexandria; *Section on Gynecology and Obstetrics*, Dr. H. W. Kostmayer, Chairman, New Orleans; *Section on Eye, Ear, Nose and Throat*, Dr. F. C. Bennett, Chairman, Monroe; *Section on Genito-Urinary and Rectal Diseases*, Dr. H. W. E. Walther, Chairman, New Orleans; *Dermatological Section*, Dr. Ralph Hopkins, Chairman, New Orleans; *Radiological Section*, Dr. L. J. Menville, Chairman, New Orleans.

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Very recently the Louisiana State Medical Society and the La. State Board of Medical Examiners lost one of their most valued members in the person of Dr. E. W. Mahler, Secretary-Treasurer of the La. State Board of Medical Examiners. Dr. Mahler had, for years, been a zealous hard-working and conscientious member of organized medicine, devoting the greater part of his time and energy in the work of which he was secretary-treasurer. As secretary-treasurer, a great many of the reform movements instituted by his board were consistently handled and cared for by him. The earnestness with which the details of his office carried him can be attested by those who were close to him in his work, the predominant feature of which was his attention to duty and his impeachable sincerity. For these and many other reasons the Louisiana State Medical Society has lost a very valuable member who, from his early professional life, has stood for those principles which are so dear to those engaged in organized medical work.

We are very glad to announce the appointment of Dr. S. M. D. Clark, Chairman of the Arrangements Committee for the approaching meeting of the Louisiana State Medical Society. Dr. Clark has already instituted plans for unusual arrangements for the entertainment of the society, both scientific and social, and I am sure that I am safe in prognosticating a very interesting and beneficial program resulting from the activities of his committee.

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The announcement of the following Post-Graduate Committee, appointed by our president at the discretion of the Executive Committee of the La. State Medical Society, is made with the belief that composed of such a personnel, in cooperation with the Committee on Arrangements and Committee on Scientific Work, it will be able to render a course in this work which will be appealing and attractive to our members. Everyone may therefore begin to make preparations to avail themselves of the unusual opportunities which will be afforded by this committee. As soon as this committee begins to function the secretary will acquaint the membership as to what they may expect in this direction. The Post-Graduate Committee is as follows: Dr. C. W. Allen, Dr. Chas. Chassaignac, Dr. J. A. Danna, Dr. I. I. Lemann, Dr. W. W. Leake, Dr. S. M. D. Clark, Dr. A. I. Weil, Dr. W. D. Phillips, Dr. M. P. Boebinger, Dr. Marion Souchon, Dr. A. O. Hoefeld, Dr. J. Landry, Dr. Robert Bernhard, all of New Orleans.

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It is my pleasure to announce, on behalf of our Councilor of the Third Congressional District, Dr. F. T. Gouaux, the organization of Assumption Parish as a component part of the Louisiana State Medical Society. Of late, unusual interest in medical affairs has been developed in this part of our state. We have received numerous applications for membership in our organization from those who, in the past, have never qualified.

Continuing this good work on the part of our State Officers, especially the active energy and cooperation of our worthy President, there has recently been organized in the Third District, a Lafourche Valley Medical Society composed of the Parishes of Lafourche, Terrebonne and Assumption. On February 15th this organization was perfected. Twenty-one members of the State Medical Society were in attendance on this occasion. Dr. W. E.

Kittredge, of Tallien P. O., was elected President of the Association, Dr. C. M. Menville, of Houma, 1st Vice-President; Dr. H. S. Smith, Thibodaux, La., was elected Secretary-Treasurer.

Other than the organization work, a very valuable contribution of a Scientific Nature was offered by Dr. H. W. E. Walther, of New Orleans, La., entitled: "The Genito-Urinary Surgeon's Field in Medicine." The Secretary-Treasurer of the State Medical Society had the privilege of attending this meeting and wishes to attest to the enthusiasm and earnestness displayed by the various members in attendance. We can therefore hope and shall feel assured that we will hear further from this district in the future on many subjects of scientific value.

If this organization can be perfected and maintained in the Third District, why is it not possible for such societies to be organized in other districts?

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At a recent meeting of the Louisiana State Board of Medical Examiners Dr. R. B. Harrison, of New Orleans, La., was elected Secretary-Treasurer of that Board, vice—Dr. E. W. Mahler, deceased.

The Council of the Louisiana State Medical Society, also the Executive Committee of this society, held two very beneficial and interesting meetings in New Orleans, La., on Saturday, February 12th, 1921. Many matters of paramount importance to the membership of our society were discussed at these meetings and plans for future development were formulated.

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Dr. W. T. Patton, Secretary-Treasurer of the Orleans Parish Eye, Ear, Nose and Throat Club, wishes me to announce a Clinical meeting of that Club for Tuesday, April 19th, 1921, to be held in the office of the Orleans Parish Medical Society, 1551 Canal Street, New Orleans, La. The membership is cordially invited.

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On January 11th, 1921, the Fifth District Medical Society held a meeting at which the following officers were elected:

Dr. F. C. Bennett, Monroe, President; Dr. A. E. Fisher, Choudrant, 1st Vice-Pres.; Dr. J. M. Funderburk, Winnsboro, 2nd Vice-Pres.; Dr. C. H. Mosely, Monroe, Sect'y-Treas. The next meeting of this District Society will be held at Ruston, on June 14th, 1921.



Hurry up and join the State Medical Society for 1921! Great things are under arrangement for the interest and benefit of the membership at the approaching Annual Meeting of this Society, April 19th, 20th and 21st, to be held in New Orleans.

If you have never enjoyed membership in our society become one of us TO-DAY! Communicate with Dr. P. T. Talbot, Secretary-Treasurer, 1551 Canal Street, New Orleans, La., and let us do the rest for you.

Organized Medicine is making great progressive strides daily and *YOU* cannot afford to be OUT-OF-STEP! Send in your application at once. Annual dues of our society are \$4.00. Let us write and tell you all that this membership entitles you to and all that your support, in becoming one-of-us will eventually mean to Organized Medicine!

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## NEWS AND COMMENT.

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ROCKEFELLER FOUNDATION TO ASSIST MEDICAL EDUCATION IN EUROPE. The Rockefeller Foundation announces a cooperative program to assist medical schools in Central Europe which covers the following points. 1. Aid in the rehabilitation of scientific equipment for medical teaching and research. 2. Aid in furnishing medical journals to universities throughout Europe. 3. An invitation to the authorities of Belgrade University Medical School to study medical education in America and England as guests of the Foundation.

It has given to France control over the elaborate antituberculosis organization established in the department of Eure-et-Loire at a cost of 4,000,000 francs. The organization consists of 24 dispensaries, four complete isolation services, a departmental sanatorium and laboratory. The system will serve as a model for similar organizations to be established throughout the country.

FORMER ORLEANS DRUGGIST OPENS BANK. L. N. Brunswig, former New Orleans wholesale druggist and now head of the Brunswig Drug Company of Los Angeles has undertaken the organization of the French-American National Bank of that city and it is understood that he will head the bank as president. French-Americans residing in Southern California are associated with Mr.

Brunswig in the movement. The Rothschild Paris interests are said to be interested.

**THE LEONARD PRIZE FOR RESEARCH.** The American Roentgen Ray Society will award \$1000.00 to the author of the best piece of original research in the field of the X-ray, radium or radio activity. The competition is open to any one living in the United States or its possessions, in Canada, Mexico, Central or South America, Cuba or other islands of the Western Hemisphere. The research matter must be submitted in literary form in the English language not later than July 1, 1921, and must never have been published. The piece of original research receiving award must be presented before the American Roentgen Ray Society at its next annual meeting in September. The prize is offered in an altruistic spirit for the promotion of useful research, with the approval of the National Research Council. It commemorates the name of a martyred member of the American Roentgen Ray Society, Dr. Charles Lester Leonard, who paid the supreme penalty for his pioneer research in the field of the X-ray. Communications to any member of the following committee will receive attention. Dr. A. W. Crane, 420 South Rose St., Kalamazoo, Michigan; Dr. P. M. Hickey, 32 Adams Ave., W., Detroit, Michigan; Dr. H. K. Pancoast, University Hospital, Philadelphia, Penn.

**CIVIL SERVICE EXAMINATIONS.** The U. S. Civil Service Commission announces an open competitive examination for the following positions, with the time limit for filing applications indicated: Dental Referee, salary \$3,600 to \$4,000 a year, and Assistant Dental Referee, \$3,000 a year. Applications will be received up to May 3. Bacteriologist, salary \$130 to \$180 a month, Associate Bacteriologist, salary \$90 to \$130 a month; Assistant Bacteriologist, \$70 to \$90 a month, and Junior Bacteriologist, salary \$70 per month, the positions carrying the bonus of \$20 for satisfactory services, the last date for filing applications being July 1.

**CHAULMOOGRA OIL AND TUBERCULOSIS.** The recent widely circulated statement that the U. S. Public Health had found that chaulmoogra oil was as efficacious in tuberculosis as in the treatment of leprosy is announced by Surgeon General Cumming as unwarranted. Recent experiments with ester, or derivatives, have been started as it is hoped because of the similarity of the bacillus

of leprosy and that of tuberculosis that this will bring about some result, but the experiments have not proceeded far enough to indicate results.

A \$500 REWARD has been offered by the Maine Public Health Association for the recovery of William A. Harris, executive secretary, dead or alive. It is believed by the Maine officials that he is suffering from mental derangement taking the form of religious mania.

FRENCH BIRTH RATE INCREASES. Vital statistics show that the birth rate increased in France in 1920. At Marseilles, for the first time in years the number of births greatly exceeded the number of deaths. At Chalon-sur-Saone the total of births for the year was 689 and that of deaths 520 only, whereas the figures for 1919 had been, births 420 and deaths 571. In Toulon the number of births exceeded by 118 the number of deaths. From Orleans and Dieppe satisfactory figures have also been communicated.

FACTS ABOUT VACCINATION. With anti-vaccination agitation attracting no little attention, it is comforting to note that the British Royal Commission on Vaccination which conducted the most thorough study ever made of the whole subject of vaccination, completely vindicates the practice as a positive protection and as an operation free from the various alleged dangers which anti-vaccinationists have from time to time set up as bugaboos.

COLUMBIA UNIVERSITY PLANS NEW MEDICAL SCHOOL. According to announcements made by W. Barclay Parsons, Chairman of the Board of Trustees of Columbia University, plans have been formulated for raising \$10,000,000 to build and endow a new medical school in connection with Columbia University, to supplement the present College of Physicians and Surgeons.

THE NEW YORK MEDICAL JOURNAL. On March 2 the *New York Medical Journal* will be converted into a semi-monthly publication. It will be enlarged, greatly improved, and its high character will be maintained. The *Journal* in its seventy-eighth year has made great strides and is today recognized as one of the most practical and influential medical journals in America.

SUICIDES IN BUDAPEST. Thirty-two hundred women and 2,100 men committed suicide in Hungary during 1920, police reports for

the past year show. More than 10,000 unsuccessful attempts are reported. This so greatly exceeds the pre-war figures, which were from fifty to sixty suicides yearly, that much anxiety is felt. The situation is attributed to the gradual deterioration in living conditions. A campaign has been begun against self-destruction.

THE AGES OF JOURNALS. *The Medical Press and Circular* has reached the very respectable age of eighty-two years, this being exceeded in Great Britain by the *Lancet*, which will soon be one hundred years old. In America the *Boston Medical and Surgical Journal* is even older than the *Lancet*, while the *Medical Record* is of middle age. The *New Orleans Medical and Surgical Journal* has nearly completed its seventy-seventh year.

ASKS NOBEL PRIZE FOR AMERICAN RED CROSS. The Finnish Government has decided to recommend to the Nobel Prize Commission that the Nobel Peace Prize be made to the American Red Cross on the ground of "its blessed activities materially relieved suffering in the war, served the purpose of humanity, and promoted mutual solidarity of the nations."

MEDICAL EDUCATION IN CHINA. Recent reports state that in all China there are to be found less than 2,000 physicians. This is an alarmingly small proportion to the population of 400,000,000 Chinese people! In an effort to ascertain the approximate number of students looking towards medicine, and to stimulate the youth of China to take up the practice of medicine, a survey has already been made of the middle schools of China. In 153 of the institutions reporting, there are 39,095 students, and of these 1,153 stated that they were planning to study medicine. Since this is only about 20 per cent. of all middle schools, the total number who may enter on the study of medicine will be considerably larger. The Rockefeller Foundation is said to have abandoned its purpose of erecting at Shanghai a great medical school similar to the Union Medical College at Peking, due to the fact that in its initial session the college had a class of only seven students although \$6,000,000 had been expended for its construction and maintenance.

OREGON STERILIZATION LAW IN OPERATION. According to an announcement of the Oregon State Board of Health, almost 100 persons have been sexually sterilized since the passage of the



Sterilization Act in 1919. The operation in each case was done by order of the State Board of Eugenics, which consists of members of the State Board of Health, the warden of the State Penitentiary, the superintendent of the State Hospital, the superintendent of the Eastern Oregon Hospital and the superintendent of the State Institution for the Feeble-minded.

**NURSES REGISTRATION BILL.** A bill, known as the Kamman bill, for fixing the standards and qualifications for registered nurses has been introduced in the legislature of the State of Indiana and is under consideration by the House Committee on Medicine and Public Health. The bill authorizes hospitals with twenty beds to establish training schools for nurses, stipulates that student nurses be graduates of common schools instead of high schools, as at present, and proposes the appointment of a state board of examination and registration to be composed of three physicians and two nurses selected from lists submitted by medical and nursing societies. The bill provides for a course of two years instead of the present three year course of instruction.

**COUNTY SOCIETY REORGANIZED.** The Assumption Parish Medical Society was reorganized in January at a meeting of physicians called by Dr. Frank T. Gouaux, Lockport, Councillor for the Third District of the Louisiana State Medical Society.

**BRITISH TRIBUTE TO AMERICAN PHYSICIANS AND NURSES.** At a testimonial dinner given recently to the Royal Army Medical Corps in London, Sir John Goodwin paid the following tribute to American physicians: "I should like to say one word on the subject with which I was rather closely connected, and that is the amount which America did for the medical service and also for the army in this war. I was sent out to America on a mission just after that nation came into the war. We were then in serious straits as regards shortage of medical and nursing personnel. I at once placed the whole situation frankly before the War Secretary, Mr. Baker. General Gorgas, Mr. Baker, the American Army Medical Service and the whole medical profession of America, placed everything at my disposal, with the result that within a very few months over 1,000 American doctors and more than 700 nurses, equipped and uniformed by the American Army, were placed unreservedly and without question, entirely at the disposal of the British armies.

Had it not been for the wholehearted help afforded to us by America, I hardly like to think of what might have happened in 1918."

**CENTENNIAL CELEBRATION OF FOUNDERS' DAY.** The Philadelphia College of Pharmacy and Science, through its Board of Trustees, Faculty and Alumni Association, cordially invited the public to attend the Centennial Celebration of the Founders' Day which was held in the College Auditorium on February 23. It is to be noted that pharmaceutical education in the country was founded by the Philadelphia College of Pharmacy.

**OFFICIAL CONTROL OF WASSERMANN TEST.** According to new regulations published in the German exchanges physicians who specialize in the examination of blood by the Wassermann technic will have to obtain a special permit to do so. They will be required to do the work under certain special conditions and use for the test only extracts which have been officially standardized. These restrictions apply only to physicians who do a laboratory business with specimens sent in from outside. They do not apply to the test in private practice or in public institutions.

**MEDICAL ADVICE TO SHIPS BY WIRELESS.** At the school of medical instruction recently established through an arrangement between the Seamen's Church Institute of New York and the Navy Department, mariners are instructed, if called on to treat a serious case of illness or accident at sea, to seek advice by wireless telegraph from the physician in charge at the Seamen's Institute until the ship reaches harbor or until assistance is obtained from another vessel. The emergency call for medical help is "KDKE" which will be entered in the international code, and will be as intelligible as the "SOS" for vessels in distress.

**SLEEPING SICKNESS SPREADS.** Reports of the prevalence of so-called sleeping sickness are coming in from very widely separated localities. The disease is on the increase in Sweden and a number of deaths from this cause have been reported in Copenhagen. The disease has appeared in Vera Cruz in a form which seems to be the same as the African disease bearing this name. A number of cases of lethargic encephalitis have been recently reported by the Chicago Health Department and the disease seems to be gaining in New York City.

TRIBUTE TO MAJOR-GENERAL GORGAS. A meeting in honor of Major-General Gorgas was held in the Pan-American Union Building, at Washington, D. C. in January, at which diplomats, officers of the Army and Navy, members of Congress and other officials were present. The exercises were under the auspices of the Southern Society of Washington, of which General Gorgas was the former president. It was voted to ask Congress to make an appropriation for a suitable memorial to General Gorgas to be placed in Washington, with a further tribute in the shape of a portrait of the late Surgeon General Gorgas to be presented to the Government by the Southern Society and to be placed in the library of the Surgeon-General's office.

PERSONALS. Mr. W. M. Danner, of New York, head of the American Mission to Lepers, visited the Louisiana Leper Home at Carville during the past month. This visit was made in the interest of the new buildings.

Dr. M. M. Carrick, of Dallas, Texas, has been appointed President for the next two years of the Texas State Board of Health.

Dr. George S. Bel has been appointed Chairman of the Medical Committee of the Board of Administrators of the Charity Hospital, New Orleans.

REMOVALS. Dr. A. Leigh has left Lecompte and is now located at Zenoria, La.

Dr. E. A. Patton has moved from Midway to Hearne, Texas.

DIED. Dr. Peter Fairley, Jackson's, Louisiana, oldest physician, died Tuesday, February 1, at the age of 81 years.

On Monday, February 7, Dr. John Philip Bergé, aged 60 years, in New Orleans.

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## PUBLICATIONS RECEIVED

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**THE YEAR BOOK**, Chicago.

**Practical Medicine Series. Pediatrics and Orthopedic Surgery**, Vol. 4, edited by Isaac A. Abt, M. D., and Edwin W. Ryerson, M. D.

**Practical Medicine Series. Eye, Ear, Nose and Throat**, Vol. 3, edited by Casey A. Wood, C. M., D. C. L.; Albert H. Andrews, M. D., and George E. Shambaugh, M. D.

**Practical Medicine Series. Surgery**, Vol. 2, edited by Albert J. Ochsner, M. D., F. R. M. S., LL. D., F. A. C. S.

**W. B. SAUNDERS CO.**, Philadelphia and London.

**Practice of Medicine**, Fourteenth edition, by James M. Anders, M. D., Ph. D., LL. D.

**Text-Book of Embryology**, Third edition, by Charles William Prentiss, and Leslie Brainerd Arey.

**The Roentgen Diagnosis of the Alimentary Canal**, Second edition, by Russell D. Carman, M. D.

**The Medical Clinics of North America**, Vol. 4, No. 3, November, 1920.

**The Surgical Clinics of Chicago**, Vol. 4, No. 6, December, 1920.

**PAUL B. HOEBER**, New York.

**The Form and Functions of the Central Nervous System**, by Frederick Tilney, M. D., Ph. D., and Henry Alsop Riley, A. M., M. D.

**Diseases of the Nose and Throat**, by Herbert Tilley, B. S. (Lond.), F. R. C. S.

**Surgery of the Lung and Pleura**, by H. Morrision Davies, M. A., M. D., M. C. (Cantab.), F. R. C. S., R. A. M. C.

**WILLIAM WOOD & COMPANY**, New York.

**A Synopsis of Medicine**, by Henry Letheby Tidy, M. A., M. D., B. Ch., F. R. C. P.

**Synopsis of Surgery**, Fifth edition, by Ernest W. Hey Groves, M. S., M. D., B. Sc. (Lond.), F. R. C. S.

**Ziegler's Pathology**, Fifth American edition, by Ernst Ziegler, M. D., revised by Douglas Symmers, M. D.

**F. A. DAVIS COMPANY**, Philadelphia.

**Heart Affections; Their Recognition and Treatment**, by S. Calvin Smith, M. S., M. D.

**Practical Psychology and Psychiatry**, by C. B. Burr, M. D.

**P. BLAKISTON'S SON & CO.**, Philadelphia.

**Hygiene**, by W. Wilson Jameson, M. A., M. D., M. R. C. P., D. P. H., and F. T. Marchant, M. R. San. I.

**Compend of Diseases of the Skin**, by Jay Frank Schamberg, A. B., M. D.

**French-English Medical Dictionary**, by Alfred Gordon, A. M., M. D., (Paris).

**W. M. LEONARD**, Boston.

**Pulmonary Tuberculosis**, by Edward O. Otis, A. B., M. D.

**THE MACMILLAN COMPANY**, New York.

**The Major Symptoms of Hysteria**, by Pierre Janet, Ph. D., M. D.

**American Red Cross Among the French People**, by Fisher Ames, Jr.

**C. V. MOSBY COMPANY**, St. Louis.

**A Little Journey to the Home of Ex-President U. S. Grant**, by C. V. Mosby.



**WASHINGTON GOVERNMENT PRINTING OFFICE**, Washington, D. C.  
**Mortality Statistics 1919**, Bulletin 144.

**U. S. Department of Agriculture, Service and Regulatory Announcements.** Supplement... Notices of Judgment Under the Food and Drugs Act. November 9, 18, and December 2, 1920.

**Public Health Reports**, Volume 35, Nos. 49, 50, 51 and 52.

**United States Naval Bulletin**, Vol. 15, No. 1, January, 1921.

**U. S. Department of Agriculture, Service and Regulatory Announcements.** Supplement. Notices of Judgment Under the Food and Drug Act. December 30, 1920, January 4, 5, 22, 25, 31, February 3, 1921.

**Public Health Reports**, Volume 35, No. 53, Volume 36, Nos. 1, 2, 3, 4.

#### **MISCELLANEOUS:**

**Hookworm and Malaria Research in Malaya, Java, and the Fiji Islands.** Report of Uncinariasis Commission to the Orient, 1915-1917. The Rockefeller Foundation, International Health Board, New York.

**The Rockefeller Foundation, Annual Report, 1919.** The Rockefeller Foundation, New York.

**Transactions of the American Otolological Society, Fifty-third Annual Meeting.** Mercury Publishing Company, New Bedford, Mass.

**Nitrous Oxide-Oxygen Analgesia and Anesthesia in Normal Labor and Operative Obstetrics.** National Anesthesia Research Society.

**Proceedings of the Fourteenth Annual Meeting of the Association of Life Insurance Presidents.**

**Official List Physicians and Surgeons, Midwives, Chiroprodists.** Louisiana State Board of Medical Examiners.

**Standard Methods for the Bacteriological Examination of Milk,** Third edition; Pasteurization of Milk, Report of Committee on Milk Supply of the Sanitary Engineering Section. American Public Health Association.

#### **REPRINTS.**

**The Better Methods of Wound Treatment—Lessons from the World War,** by Henry O. Marcy, A. M., M. D., LL. D.

**The Recent Increases in Venereal Diseases,** by Thomas E. Satterthwaite, M. D.

**How "Tuberculosis Schemes" Fail and Why,** by Stephen J. Maher, M. D.

**Des Actions Musculaires Artificielles,** by Dr. Gabriel Bidou.

**The Effects of Syphilis on the Families of Syphilitics Seen in the Late Stages,** by Harry C. Solomon, M. D., and Maida H. Solomon, A. B., B. S.

**The Reactions of the Arsines,** by Roger Adams and Charles Shattuck Palmer.

**The Value of the Cultural Method in the Diagnosis of Chancroid,** by Oscar Teague and Olin Deibert.

## MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for January, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	1	1	2
Intermittent Fever (Malarial Cachexia)			
Smallpox	6	8	14
Measles	10		10
Scarlet Fever			
Whooping Cough			
Diphtheria and Croup	1		1
Influenza	6	3	9
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	43	32	75
Cancer	18	7	25
Rheumatism and Gout	1	1	2
Diabetes	10	2	12
Alcoholism			
Encephalitis and Meningitis	3	2	5
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	20	15	35
Paralysis	1	2	3
Convulsions of Infancy			
Other Diseases of Infancy	13	9	22
Tetanus			
Other Nervous Diseases	7		7
Heart Diseases	66	35	101
Bronchitis	1		1
Pneumonia and Broncho-Pneumonia	37	29	66
Other Respiratory Diseases	1	1	2
Ulcer of Stomach	3	1	4
Other Diseases of the Stomach	2	2	4
Diarrhea, Dysentery and Enteritis	14	10	24
Hernia, Intestinal Obstruction	7	3	10
Cirrhosis of Liver	3	2	5
Other Diseases of the Liver	2		2
Simple Peritonitis			
Appendicitis	10	3	13
Bright's Disease	30	9	39
Other Genito-Urinary Diseases	9	5	14
Puerperal Diseases	5	3	8
Senile Debility	1		1
Suicide	5		5
Injuries	28	15	43
All Other Causes	28	21	49
TOTAL	393	219	261

Still-born Children—White, 17; colored, 28; total, 45.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 16.26; colored, 23.89; total, 18.36. Non-residents excluded, 15.90.

## METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure ..... 30.22  
 Mean temperature ..... 59  
 Total precipitation ..... 1.16 inches  
 Prevailing direction of wind, southwest.

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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EDITOR: CHAS. CHASSAIGNAC, M. D.

## COLLABORATORS:

P. T. TALBOT, M. D., Secretary Louisiana State Medical Society.....*Ex-Officio*  
H. D. BRUNS, M. D., Tulane University of Louisiana.  
S. T. DARLING, M. D., Sao Paulo, Brazil.  
W. H. DEADERICK, M. D., Hot Springs, Ark.  
T. J. DIMITRY, M. D., Loyola University, New Orleans, La.  
E. M. DUPAQUIER, M. D. (Paris), New Orleans, La.  
A. G. FRIEDRICH, New Orleans, La.  
J. T. HALSEY, M. D., Tulane University of Louisiana.  
JOS. HOLT, M. D., New Orleans, La.  
E. S. LEWIS, M. D., Tulane University of Louisiana.  
R. MATAS, M. D., Tulane University of Louisiana.  
AUGUSTUS McSHANE, M. D., New Orleans, La.  
PAUL MICHINARD, M. D., Tulane University of Louisiana.  
C. J. MILLER, M. D., Tulane University of Louisiana.  
F. W. PARHAM, M. D., Tulane University of Louisiana.  
W. H. SEEMAN, M. D., Tulane University of Louisiana.  
EDMOND SOUCHON, M. D., Tulane University of Louisiana.  
J. A. STORCK, M. D., Tulane University of Louisiana.

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Vol. 73

APRIL, 1921

No. 10

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## EDITORIAL

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### LAST CALL FOR THE 1921 STATE MEETING.

We hope that all the members of the State Medical Society who can manage to get off, even with some degree of sacrifice, are preparing to attend the session to be held in this city on the 19th, 20th and 21st of this month.

The program we publish elsewhere promises a large measure of scientific endeavor and the list of entertainments shows that the social side of the meeting has not been neglected. We mention both in the same breath, as it were, because we attach equal importance to the cultivation of closer personal acquaintance and relation between the members as to the more direct co-operation in professional work represented by the reading, hearing and discussing of medical papers.

In addition, the committee of arrangements, through a sub-committee, has secured more attractive opportunity for clinical obser-

vation and post-graduate instruction than has ever before been offered to the members and it is hoped that this will appeal to a sufficient number to aid in swelling the attendance considerably.

In short, nothing has been neglected for the edification and entertainment of a goodly number at this session and the proportion who respond will demonstrate whether the effort involved has been worth while or not.

We trust the local members will not be disappointed and that once more the attendance record will be smashed.

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### THE LEPTOSPIRA ICTEROIDES.

Probably because we have been many times disappointed after the discovery of the causative agent of yellow fever has been heralded with ever recurring assurance, what now seems to be a really successful demonstration by Noguchi has not been received with the enthusiasm it should provoke.

Noguchi did his experimental work in Guayaquil, whither he had been sent by the Rockefeller foundation, and its results have been confirmed by similar experimental work in Mexico and in Peru. He first communicated yellow fever to guinea-pigs by means of blood from yellow fever patients and in emulsions of kidney and liver of the guinea-pig he found, under dark ground illumination, the organism which he called the leptospira icteroides on account of its resemblance to the leptospira icterohemorrhagiae, the causative agent of infectious jaundice.

The leptospira icteroides is very minute and delicate, quite sensitive to heat, does not stand either dessication or freezing, and passes through the closest bacteriologic filters, hence its characteristics correspond to what was already known of the properties of the virus of yellow fever.

Noguchi further showed that the stegomyia mosquito carries the organism by having yellow fever patients bitten by these mosquitoes on the third day of their disease and then having the mosquitoes bite the guinea-pigs, the latter developing typical yellow fever and showing leptospira in their blood. The mosquitoes which had carried the infection were shown to contain leptospira also when they were crushed and their contents in emulsion were examined under the dark ground illumination. The identity of



the experimental disease in the guinea-pig and true yellow fever in man is additionally proved by careful clinical comparison and a study of the pathological aspects of the two. When the leptospira icteroides is found in blood or tissues the material proves to be infectious.

From all the above and other evidence adduced, we can summarize the evidence, showing that the leptospira icteroides is the causative agent of yellow fever, thus: it has been found in yellow fever patients and cultivated from them in several parts of the world and by different observers; inoculations of its culture have produced the disease in guinea-pigs; it is carried by the stegomyia mosquito and cannot live outside of its body or the blood of patients; guinea-pigs inoculated with the blood of yellow fever patients are subsequently immune against the organism and the serum of convalescents from yellow fever protects against infection by the organism, and the latter is agglutinated by said serum.

Noguchi's discovery is of great importance scientifically and from the public health standpoint, although from its scarcity in the circulating blood and the slow effects of its inoculation in the guinea-pig its value is not pronounced in diagnosis.

The good results already obtained with an anti-icteroid serum in the treatment of the experimental disease may in time lead to a great improvement in the treatment of human cases. Noguchi has used vaccines made with dead cultures of the leptospira, but results, as published, are yet indecisive.

We can be surer than ever that isolation of patients suffering from yellow fever and the destruction of stegomyia are sufficient to arrest the progress of the disease and to give the expectation of stamping out the disease.

In the meantime would it not be well to renew the fight against the stegomyia in this state which still possesses numerous cisterns many of which are yet unscreened or whose screens are in a state of decay?

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### SUBACUTE INFECTIVE ENDOCARDITIS.\*

Dr. I. I. LEMANN.

The topic of this paper has an especial timely and melancholy interest because of the death within the past year of a highly honored member of our profession in this State. The course of the disease in him has seemed to me to hold such important lessons learned anew as to warrant a brief review of the subject. This is my excuse for presuming to offer you old wine in new cups.

At the outset I desire to direct your attention to the name of the disease and to point out the differentiation of this malady from other affections of the heart with which it is too often indefinitely and vaguely grouped. It is not my purpose to consider this evening any phase of acute endocarditis, for example, nor any purely chronic malformation of the valves arising from attacks of acute rheumatic fever. The clinical entity is well described by the several synonyms by which it is known: 1 Subacute infective endocarditis, 2 Subacute (or chronic) malignant endocarditis, 3 Subacute ulcerative (or vegetative) endocarditis, 4 Endocarditis Lenta (i. e. "slow endocarditis"), 5 Septic endocarditis. The distinguishing characteristics, therefore, are its subacute type, its malignancy, its septic course and its pathology—namely vegetations and ulcerations upon the valves and inner wall of the heart. To this should be added its almost exclusive selection of hearts already previously the site of rheumatic endocarditis, or syphilitic or arteriosclerotic changes.

As I have already said, this disease cannot claim our attention by reason of its novelty. Osler in his Goulstonian lectures in 1885 referred to it and later called prominent attention to it. It was certainly known and described by French authors as early as 1871. Especially in the last decade, however, a great deal has been written concerning it and important contributions have been made

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\* Read before the Orleans Parish Medical Society, February 14, 1921.

to our knowledge of its symptomatology, etiology and pathology, particularly by American colleagues—Libman, Rosenow, Billings, Baehr and others. Libman has had the largest experience and has made the subject his particular province. To him we owe the most extensive clinical descriptions as well as the most intensive studies from a pathologic and etiologic standpoint. Thus, writing in 1918, he says that he had seen up to 1917 nearly 300 cases, in 182 of which he had notes, and he had witnessed at least 65 postmortem examinations.

When one man has seen as many as three hundred cases of a single malady, this can hardly be considered to be of unusual occurrence. Nor do I consider it such if I may judge from my own experience. In the two years of practice since my return from army service I have seen at least six cases. On the other hand I have found in the Charity Hospital published reports only one case set down as chronic septic endocarditis in a total of 160,044 admissions during the ten years from 1910 to 1919. No diagnosis of subacute infective endocarditis was made. During this period thirty-one cases of acute infective endocarditis are reported and it is possible that some of these should properly be classified as belonging to the category we are now discussing. I have tried to analyze the histories of these so-called acute endocarditis cases as far as the data furnished will permit and have arrived at the conclusion that perhaps 10 or 11 of them may justly be transferred to our classification. Thus, even with these included we find that the Charity Hospital has but one case of subacute infective endocarditis per year or an average of one in about 16,000 admissions. From this we must conclude either that it is indeed of an unusual occurrence or that its diagnosis is often missed. I am somewhat inclined to the latter opinion on the ground I have already stated, namely, that my own collection shows a glaring disparity with these figures. There is no reason why an undue proportion of these cases should have fallen under my notice. I wish to disclaim at once any unusual diagnostic acumen in discovering these. It is merely that sad experience has taught me to look for them.

When the numerous pitfalls which beset the diagnosis are taken into consideration it is not remarkable that the condition is so often mistaken for something else. In our friend's case the insidious onset, the fever, the loss of weight, the anorexia, led others,

as well as myself into the erroneous diagnosis of pulmonary tuberculosis. This diagnosis was apparently fully confirmed by the skiagraphs of the chest. There is no doubt that an old pulmonary lesion did exist, but it was healed and not responsible in any way for the malignant course of the disease which carried him off. Our attention being then focused upon the pulmonary condition, we missed at first the significance of the old valvular disease, which he knew he had had for years, and the role it was playing in his present illness. It was not until the occurrence of a renal embolism (which with its pain and hematuria simulated renal colic or other essential renal disease) that the truth became evident to me. Then it was all too plain. The old endocarditis, the septic fever, the painful skin nodules and petechiæ which had also meanwhile made their appearance, as well as a positive blood culture rendered complete the clinical picture.

Last year I saw a young woman who had had an old rheumatic endocarditis since childhood and who for several months was having an irregular fever. I was assured that the pelvic organs were normal. The blood examination showed no plasmodia and no leucocytosis. No focus of suppuration was discoverable. I expressed the opinion that she was suffering from subacute infective endocarditis. A few weeks later a colleague smilingly informed me that the diagnosis was erroneous for the patient has finally confessed that she had attempted or actually performed an abortion upon herself. Her fever, he therefore, with much justice considered to be due to a pelvic infection. The sequel, however, proved quite otherwise. She continued to have the septic fever although walking about and attending to her household duties. The catemenia were normal and there were no pelvic symptoms. A competent gynecologist could find no evidence of any pelvic inflammation. The frequent occurrence of petechiæ and painful skin nodules finally set at rest any doubt as to the diagnosis. The patient had fever for about nineteen months and developed the usual secondary anemia as well as the usual glomerular nephritis. Death occurred following a pulmonary embolism. See how easily, therefore, it is for the unwary to step into the pitfall set by a clear cut history of pelvic infection. In another recent case the fever had been erroneously attributed in turn to pulmonary tuberculosis and to gall-bladder infection. Another illuminating experience was



furnished some years ago by an unmarried young woman of about 25 years who consulted me on account of headache. For several years, she told me, she had had an attack of fever lasting several weeks each spring or summer, which was diagnosed malaria though no blood test had ever been made. She had an old rheumatic endocarditis since childhood which had always been easily recognized by every one who had examined her. A short time later I was summoned to see her in an attack of fever. No plasmodia could be found on repeated examination. There was no leucocytosis. Typhoid was at first suspected but it was not very long before the mystery was cleared up by the occurrence of petechiæ, painful skin nodules, an embolism of the spleen causing terrific pain, and the finding of streptococci in the blood stream. I have often wondered whether the previous attacks of fever could possibly have been due to similar infections of the diseased valves, healing each time and again becoming infected. If this were true, it would be a singular case in the literature though Libman has proven that healing may and does occur at least once. This patient finally succumbed (as all patients I have seen) after nearly a year's illness. The disease, therefore, may easily be mistaken for tuberculosis, septicemia from other causes, malaria, typhoid. Particularly may we be led astray as to the latter two because the spleen is so frequently enlarged in infective endocarditis.

There are some very striking characteristics which if borne in mind, will assist materially in the diagnosis. First of these and most important is that the disease occurs nearly always in people with previous valvular defects. Any patient with an old lesion, therefore, who acquires a septic temperature or even a temperature of low grade, should be regarded with suspicion. Such patients may go around for a long time and attend to their duties not recognizing that they are seriously sick. Evidence of cardiac insufficiency is often absent until late in the disease and then is due to exhaustion and the profound anemia. In fact, it may be said that the streptococcal infection attacks by preference those hearts which have never been decompensated. On the other hand, patients with decompensated hearts may have succumbed before they have become infected or without having been subjected to the possibility of infection. New murmurs according to Libman are unusual and this coincides with my experience. Others have re-

ported the appearance of new murmurs at the time of the infection or the exaggeration of old ones. Arythmias are remarkably infrequent. In a recent case I noted what seemed to be a paroxysmal tachycardia. Next to the septic temperature, and occasionally chills, the most striking phenomena are those produced by emboli, either bacterial or due to small pieces of the vegetations from the valves. The petechiæ, the painful skin nodules first described by Osler, the renal and splenic emboli I have already alluded to. To these must be added emboli into the bone marrow sometimes simulating osteomyelitis or periostitis and accounting probably for the tenderness over the sternum, emboli into retinal vessels and into cerebral vessels causing respectively disturbance of vision and paralysis.

It is beyond the scope of this paper to discuss etiology and pathology. As you know, while the majority of the cases are caused by a non-hemolytic streptococcus, some infections with *B. influenzae* and with the pneumococcus have been reported. Rose now has raised the point as to whether the non-hemolytic streptococcus and the pneumococcus are not identical, simply adopting varying characteristics under varying conditions. The portals of entry of the infecting organism are unknown but it has been repeatedly suggested that these may be found in some focal infection—teeth, tonsils, etc. It would not be fair to pass the topic of pathology without at least a reference to the painstaking work of Libman showing the evidences of organization and healing in many of the lesions at postmortem, which he has tried to correlate with the fact that the blood stream of patients *intra-vitam* is often bacteria free.

When we turn to prognosis, however, we are unfortunately unable to assign great value to the freeing of the blood stream from bacteria. The bacteria free patients die as well as those whose blood still yields a positive culture. The bacteria free patients continue to have the same symptoms. The tendency to heal rarely reaches the fully healed stage. Practically the malady is uniformly fatal. Here and there in the literature is an isolated report of a recovery. Libman knew of four recoveries in his three hundred cases. Death occurs from exhaustion, anemia, glomerulo-nephritis, or cerebral embolism usually.

With such record the recommendations for treatment can be of

little help. So far all that can be said is that we should attempt to increase the patient's powers of resistance by rest and food. To this end an early diagnosis before the patient's strength has been seriously undermined is essential. The facts that the lesions tend to heal of themselves and the blood stream spontaneously becomes bacteria free should hold out the hope that we may some day be able to find a remedy which shall increase that tendency or by reason of its chemotaxis reduce the virulence of the infecting organisms. This hope is somewhat strengthened by the observation that chills occurring either spontaneously or after any form of intravenous medication causes the blood stream to become at least temporarily bacteria free. Up to now, however, all attempts at specific medication have proven futile. Certain it is that vaccines whether stock or autogenous are useless if indeed they are not positively harmful.

#### DISCUSSION.

**Dr. S. C. Jamison:** Negative blood cultures in the best hands, often repeated, should not influence us against making this diagnosis. In the majority of cases, such cultures are negative. I have seen at least two cases of acute septic-endocarditis which were apparently cured by transfusion. I have never seen transfusion tried in a sub-acute case, but am inclined to think that it might be of benefit, and, as these cases present a rather hopeless prognosis, I believe that a simple method of this kind should be tried.

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### ACUTE NEPHRITIS IN SYPHILIS.\*

By D. N. SILVERMAN, M. D.,

Since Perroud's early contribution, in which was first described a possible acute nephritis due to syphilis, most writers on the subject, from that time to the present, have come to the conclusion that the disease is of difficult diagnosis and of rare occurrence. Many of these difficulties in diagnosis were demonstrated by Stokes<sup>1</sup> in his recent report of a case of parenchymatous nephritis. Cole,<sup>2</sup> likewise, convinces us that exacting conditions must be satisfied before a definite diagnosis can be made. Especially is this true where mercury has been administered previous to development of the nephritis. Fournier, recognizing this fact, laid down certain requirements, upon which he bases the syphilitic origin of the

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kidney disturbance. This author, quoted by Legue, observed syphilitic nephritis of various types in only nine out of 3429 cases of nephritis. Thompson,<sup>3</sup> in recent years, has seen but one case of acute involvement of the kidney in several hundred cases of early syphilis, although many others manifested mild transient albuminuria.

In spite of its rarity, Cabot speaks of acute parenchymatous syphilitic nephritis as "one of the two forms of syphilitic infection in which the symptoms and pathology can be actually attributed to the spirocheta pallida. The other is a gummatous kidney."

The following cases of acute nephritis had no arsenic or mercury prior to coming under our observation. Being unable to account for any other etiological factor in either of them, the presence of syphilis promoted investigation to establish a possible relationship between the nephritis and the treponema.

CASE 1. E. M., white female, aged 13, was admitted to the Touro Infirmary December 24, 1917. The chief complaints were, to use the words of the patient, "headache and swelling of the skin."

**Past History.** Previous to the present trouble, she had been in excellent health for two and a half years. She stated that at that time, "because of diphtheria," the tonsils were removed. The claim of diphtheria evidently was a mistake and tonsilitis pronounced the correct trouble.

The family history was negative, with the exception of the father, who died of heart disease at 56.

**Present illness.** Present illness started suddenly one morning five days before coming to the hospital. The patient stated that there was severe headache, nausea, vomiting and swelling of the eyelids. Within a few hours the entire face became swollen and two days after the whole body was swollen. She could not breathe with ease and had to sit up to sleep.

**Physical examination.** General edema of face and extremities, with evidence of ascites. Ear, nose and throat negative for any gross pathology. The aortic second sound was markedly accentuated. Blood pressure was 165 systolic. Lungs and other organs apparently normal. Urinalysis revealed a very high percentage of albumin, not accurately determined, a few red blood cells and leucocytes. The 24-hour specimens varied in quantity from 900 to 1200 c. c. Blood counts were normal. Wassermann reaction strongly positive.

Without evidence of another cause for this acute kidney condition, we decided to treat our patient for syphilis and by the therapeutic test try to establish a diagnosis.

On mercurial inunctions, half drachm every night, the edema subsided and the blood pressure was appreciably reduced within a week.

On the seventh day of her stay she was up in a chair. Not being willing to remain in the institution any longer, mercury and iodides in



small doses were prescribed by mouth. The patient escaped observation for two and a half years, when I finally traced her whereabouts and made a further study of the results of our previous treatment. She had been complaining of frequent headaches and had seen two physicians in the meantime. She stated that they had been unable to detect any signs of kidney disease.

April 12, 1920, examination revealed slight puffiness of the lids. The aortic second sound was accentuated. Blood pressure readings, 110 systolic and 78 diastolic. Urine showed a few granular casts, but no trace of albumin. Wassermann reaction slightly, but distinctly, positive. Iodides relieved her headache to some extent. Examination of the eyes at this time was negative, except for error of refraction.

This case is one of acute nephritis, where clinically the kidney lesion is certainly of close relation to the existing syphilis. There was no other accountable cause and the disease responded promptly to anti-specific medication; yet the difficulty in definite diagnosis lies in the absence of sufficient proof that the case was one of recent syphilis.

CASE II. I. M., colored male, aged 14. First seen in the Charity Hospital on July 16, 1920. He stated that he came for treatment "because his brother brought him," otherwise he felt well. We could not obtain any information of value relative to his family and past history.

**Present illness.** Having felt perfectly well, he broke out with "sores over his entire body" about five weeks previous to admission. These signs were soon accompanied by sudden swelling of his face, abdomen and lower extremities. There was slight dyspnea, but sleep was not disturbed. The boy was unable to give any further history other than that no treatment had been administered. Temperature normal and remained so while under observation.

On physical examination patient presented general anasarca, most marked about the face and abdomen. The entire skin showed a generalized eruption of dark brown macules, some of which had begun to scale, as shown in Figures 1 and 2.

Special dermatological examination resulted in a diagnosis of macular syphilide. All the superficial lymph nodes were greatly enlarged. The eyes received the usual and ophthalmoscopic investigation and were found normal. There were no mucous patches and the laryngologist reported the tonsils free of disease. All of his teeth were in good condition. Thyroid not enlarged.

**Heart.** Accentuated aortic second sound, but otherwise negative. Blood pressure readings, 186 systolic; 124 diastolic. Lungs. Normal. Abdomen. Markedly distended, ascites being present. Liver and spleen. Not palpable. Penis. Edematous, but not showing evidence of primary lesion. Scrotum the same.

Reflexes were slightly exaggerated. Blood count normal. Blood Wassermann strongly positive.

Urinalysis bore further evidence of acute nephritis, with the albu-

min content of three and five-tenths per cent. by volume. Numerous hyaline and granular casts, many leucocytes and red blood cells. Phenol-sulphonphthalein test subcutaneously read 65% in two hours.



We could thus far state the possibility of acute nephritis. The decision rested between syphilis present in every sense of the word, and some other factor undeterminable by thorough examination as a probable cause. A trial dose of neoarsphenamin, .3 gr., was administered intravenously July 20, 1920 all other therapy having failed to give results. July 22, 1920, albumin dropped to 1.5% with some reduction of the edema. On the next day his blood pressure readings were 124 systolic and 80 diastolic. The next day there was a rise in albumin contents to three per cent., while the facial edema disappeared. At this point, we decided to follow the line of treatment as described by Ormsby,<sup>5</sup> namely, small doses of the drug at frequent intervals. His technic had previously been employed in uncomplicated cases. We thought this a good opportunity to carefully try its value in a most complicated case.

July 22-25. Four-tenths of a gram of nearsphenamin was given with quite beneficial results. The albumin reading dropping to its lowest point, .3% two days later. A temporary exacerbation took place on July 26, the albumin rising to 4½% and the blood pressure to 165 systolic and 110 diastolic, which were still somewhat lower than the readings before treatment was begun. The third dose of nearsphenamin, .4 gram, was given with hesitation. In two weeks, the albumin content was reduced to 1%, the blood pressure readings were the lowest recorded, namely, 120 systolic and 80 diastolic, practically normal. The edema had subsided and the macular eruptions faded entirely. Unfortunately our patient left the hospital at this interesting stage of the treatment.

Unlike the first case in the record, we were unable to follow up the ultimate results of our treatment and thereby prove its undisputed syphilitic nature. However, we can frankly state that nearsphenamin was beneficial and the signs of nephritis gradually subsided under its use. I wish to express my appreciation of the valuable aid that was rendered by Dr. J. M. Hoffman, Charity Hospital, in this work.

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#### DISCUSSION.

**Dr. S. C. Jamison.** In discussing this subject, it should be borne in mind that syphilis is an etiological factor to be studied in all types of nephritis, and that a Wassermann reaction should be done as a routine in all cases in which the etiology is at all obscure.

This was a much more difficult subject ten or twelve years ago when the Wassermann reaction was in its infancy. I can recall one case, however, who was apparently in uremic coma with suppression of urine, who apparently made a complete recovery under inunctions of mercury. We must also remember that mercury particularly, and salvarsan sometimes, may cause nephritis; also that a positive Wassermann may be encountered in nephritis, which does not mean at all that syphilis is the basis of the kidney lesion.

**Dr. Allan Eustis.** "I arrived too late to hear Dr. Silverman's entire paper, but was very much interested in the reports of his cases. Syphilitic infection of the liver is a well recognized clinical entity, but we also find severe nephritis in a syphilitic. I would caution against the use of mercury by mouth or hypodermatically, in the latter type if there is much involvement of the kidney. Mercury, we know, is a definite renal irritant, and an acute anuria can be produced with very



small amounts of mercury if the absorption is rapid, and elimination poor on account of an already diseased kidney. I have had the disagreeable experience of having a patient with a phenolsulphonephthalein test of 5% in two hours develop a complete anuria, salivation, coma and death, after taking one quarter of a grain of protoiodid of mercury three times daily, for three days. I feel convinced that the mercury hastened the fatal termination in this case. I believe that when indicated mercury should be given to these cases by injunction, as was done in Dr. Silverman's cases.

**Dr. W. H. Harris.** Dr. Silverman's well presented paper appears to me to be of much value in that it calls our attention to a clinical condition no doubt quite frequently overlooked. In the current nephritis case encountered, it is usually the custom to regard the condition as a sequel of some of the exanthemata, pregnancy, exposure, teeth or tonsil lesions and alike, and to consider the condition 'per se', without the realization of a possible general syphilitic process with a kidney lesion as one of the component parts. The advantage of including syphilis as a possibility is, of course, important in that if such is the case a definite line of treatment is available which may be of great value.

From a pathological viewpoint we often appreciate the presence of kidney lesions in congenital syphilis. In the adult we are more apt to find gummata and sclerotic scars of tubule destruction or glomerular obliteration, probably due to lesions of the branches of the renal vessels (obliterating endarteritis).

A general diffuse syphilitic lesion is not often recognized although I have seen such conditions and have microscopic sections from such a case showing generalized distribution of spirochetes through the kidney histology, with retrograde changes in the epithelial cells.

Even though one may question the significance of a positive Wassermann and the improvement of such cases by special treatment, the demonstration of spirochetes throughout the kidney substance definitely eliminates the doubt of the occurrence of such lesion as Dr. Silverman has described. Again it may be possible that if special stains as the Levaditi were carried out upon more of our nephritis kidneys, spirochetes may be more frequently encountered.

The Doctor's paper is, no doubt, of distinct value in that it brings before us the important clinical observation that is no doubt overlooked in some instances by the general clinician.

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## HEMORRHAGIC OSTEOMYELITIS OF THE FEMUR.

By PAUL G. LACROIX, B. S. M. D., Junior Associate Surgeon Touro Infirmary;  
 Demonstrator in charge of the Laboratory of Minor Surgery, Tulane University,  
 New Orleans.

The histo-pathology of hemorrhagic osteomyelitis has brought forth much discussion and has not, as yet, been definitely settled. Until comparatively recently it was regarded as malignant and treated by amputation. However, Barrie, Platou and Bloodgood



have concluded that when thoroughly removed this condition does not recur or if it does recur, that it can be removed again without any fear of metastasis.

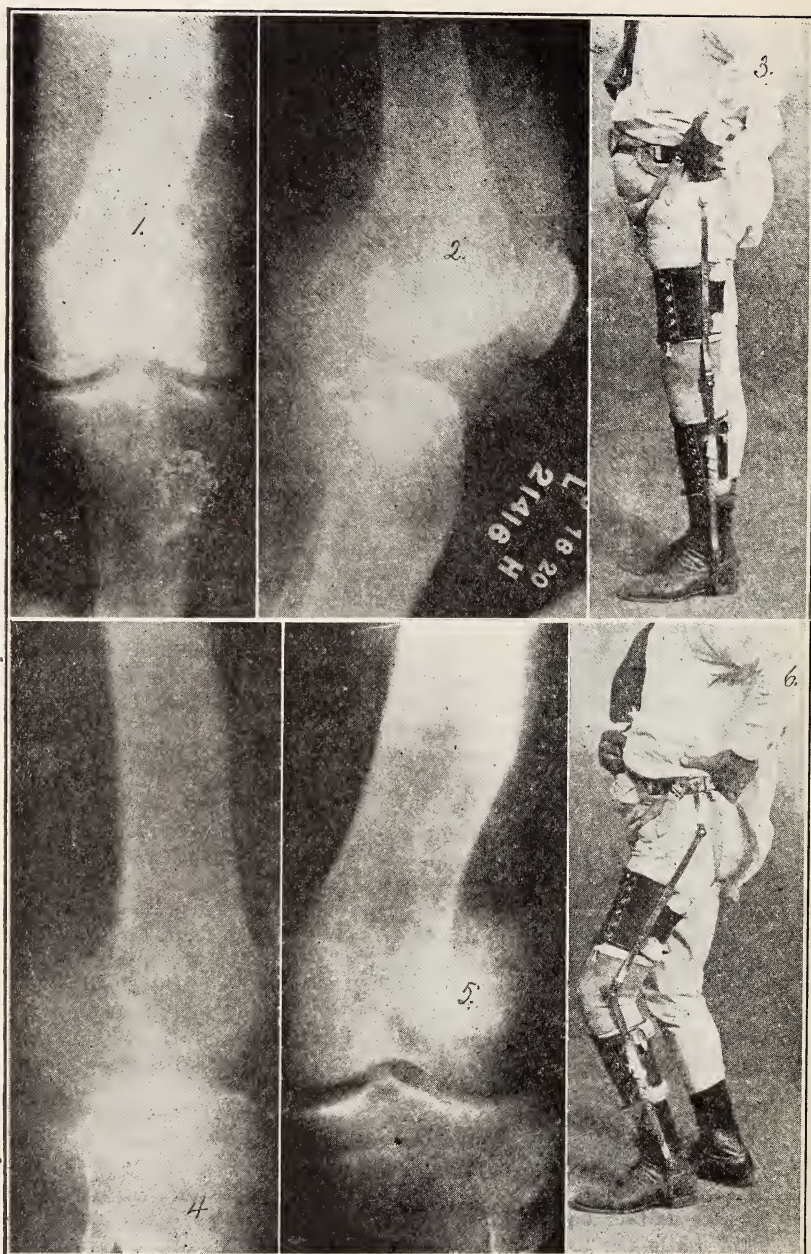
According to Barrie and Bloodgood, this condition usually occurs in the bones that are exposed to the greatest trauma and a history of trauma, whether slight or severe, usually precedes the onset of definite signs of bone lesions. The pain, which is deep seated, persistent and boring in character, is not marked until swelling around the joint is observed.

The history was as follows: Mr. E. B., 45 years of age. In February, 1920 he twisted his left knee; this was followed by slight swelling and pain. The swelling disappeared in a few days, but the pain was so persistent that he thought it was due to rheumatism. He, therefore, used anti-rheumatic remedies but without any beneficial results. Although the knee was painful he was still able to walk around. On May 15, 1920, while helping to hoist a heavy piece of machinery he slipped, again "wrenching" as he said, the left knee. At the time he felt and heard a "clicking" in the knee joint. Immediately following the second injury, the pain was so severe that he was unable to walk or even bear any weight on the leg.

Physical Examination: White male, well developed and nourished. The lungs, heart and abdomen are negative. The left knee is held in a semi flexed position; the circumference is 17 inches while that of the right knee is 15 inches. The skin over same is glazed; there is fluctuation over the anterior and outer aspect of the knee. Flexion and extension are very painful and limited to 30 and 120 degrees respectively. On palpation, a mass 6 by 3 inches is felt attached to the lower one-fifth of the shaft and external condyle of the femur; it is non-fluctuating and very painful to touch. Temperature 98.3; pulse 80 regular and full. The blood count was normal. The radiographic examination Figure 1, shows: "extensive hemorrhagic osteomyelitis, involving the lower portion of the left femur on the outer side. The lateral view, Figure 2 also shows this condition well. There is no apparent involvement of the bones of the leg."

On May 19, 1920, under ether anesthesia an incision was made over the outer aspect of the knee, beginning at the level of the lateral condyle of the tibia and extending upwards for 12 inches. The bony tumor was then exposed. The periosteum was removed, but in doing so the thin wall of the tumor was perforated. It was about the thickness of an eggshell. About six ounces of a gelatinous reddish brown material were then scooped out. The walls were chiseled away and as the external condyle was similarly affected, it, too, was removed. The joint cavity was neither curetted nor irrigated. The capsule was sutured to the skin while the upper and lower angles of the wound were sutured with silk worm gut. An incision three inches long was made over the inner aspect of the knee. Here, too the capsule was sutured to the skin. A simple dressing was then applied.

The microscopic examination by Doctor John A. Lanford is as fol-



1. Radiograph in antero-posterior position, before operation. 2. In lateral position, before operation. 3. Application of the caliper brace. 4. Radiograph in lateral position, after the operation. 5. In antero-posterior position, after operation. 6. Shows amount of flexion finally obtained.

DR LACROIX'S ARTICLE.



lows: Several areas of neoplasm made up of fibroblasts are noted. The younger cells present a well defined nucleus with a scanty cytoplasm. Among these cells are seen a few large giant cells of the foreign body type. The tumor cells are differentiating into myxomatous type tissue, connective tissue and bone. In other areas a large amount of free blood and some inflammatory exudate are noted. The tumor is somewhat vascular in character. Diagnosis, hemorrhagic osteomyelitis.

Immediate active mobilization, as advocated by Willems, was commenced as soon as the patient had recovered from the effects of the ether. He was told to move the leg every hour, but as he realized that this relieved the pain, he eagerly moved it at shorter intervals. The wound healed by first intention, having completely closed one month after the operation. Other than developing a thrombophlebitis of the lower extremity, his convalescence was normal. On August 10, 1920 a caliper brace, Figure 3, extending from the groin to the sole of the shoe and having a movable ankle and knee with a sliding joint was applied, thereby removing the weight from the knee and enabling the patient to walk around freely and free from pain. On September 1, 1920, he returned to his former occupation (welder) and says that he is able to work just as much now as before the injury. Another radiograph, Figures 4 and 5, taken September 28, 1920, shows that "the cavity is being filled with new bone." On January 25, 1921, eight months after the operation, there is neither any pain nor any signs of the return of the growth; there is some lateral motion at the knee joint; extension is not limited, but there is a limitation of flexion to about 70 degrees as shown by Figure 4. Figure 3 illustrates the application of the caliper brace.

- SUMMARY: (1) This condition was not considered to be of neoplastic origin.
- (2) By the more conservative method of treatment—complete removal and curettage—all symptoms have been relieved.
- (3) The immediate use of Willems' method gave a movable joint instead of a stiff one.
- (4) The weight from the knee was removed by the application of a caliper brace.

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## A CASE OF RETINITIS PROLIFERANS.

By JULES DUPUY, M. D., New Orleans.

The following case presents certain anomalous or pathologic conditions, which I think will prove interesting.

**History.** Cassie Cook, colored female, aged 14, presented herself at Charity Hospital service of Dr. T. J. Dimitry on Nov. 2, complaining of burning and pain of both eyes but especially the right, and more marked after close work.

There was nothing unusual, interesting, or suggestive in her family history. She had always been fairly well and strong. History was given of the following diseases, whooping cough at 8, measles at 11, chicken pox at 13, and influenza during the last epidemic. No unusual menstrual disturbances.

**Examination.** A fairly developed and well nourished girl presenting no gross abnormalities.

Both eyeballs are normal in position and move freely in all directions.

The palpebral openings and lids are negative, likewise is the region of the lacrimal sac and lacrimal apparatus. The conjunctiva of the lids, fronices, and eyeballs present nothing abnormal. The sclera is negative.

Both corneae are of equal size, form, and curvature, and the surface condition of the epithelium is negative. No opacities are present, and the sensitiveness is normal.

The anterior chambers are of equal depth and the contents are clear. Nothing unusual is noticed about the iris. Both pupils are round, centrally placed, equal and react to direct and indirect light and accommodation.

The lens is free from any visible opacity. The intraocular tension is normal.

Ophthalmoscopically the left eye is negative. The right eye presents the interesting features of the case. Attached to the center of the disc at the point where the retinal artery enters and the retinal vein leaves is seen a veil-like membrane slightly fibrous at its origin extending right after its origin about one and a half mm. into the vitreous and apparently attached or agglutinated to several of the larger vessels. From here it sweeps over to the temporal region assuming a fan-like form in its course. About 2mm. from its origin is seen a rather dense collection of pigment granules, and, here and there scattered over the membrane are smaller collections of pigment. No new blood vessels are seen in this structure, and it is fairly transparent except where the pigment is placed. The membrane becomes so thin as it reaches the temporal part of the retina that I could not tell whether it remained out in the vitreous or is attached distally to the retina. The descending retinal artery makes a distinct loop of about 1mm. out into the vitreous, and the nasal branch passes over a branch of the retinal vein which seems to be deeply imbedded into the retina proper. No vitreous opacity or any other abnormality was observed.

The vision was O. U. 20/40. The visual form field was peripherally contracted, though not to any great extent. The color fields are within the normal limits, but slightly irregular and overlapping. No scotomata are present.

She retinoscopes O. U. + O. 50S, but would not accept a lens with the trial case.

Examination of her ears, nose, and throat are negative. An X-ray of her cranium and sinuses likewise revealed no information. A blood Wassermann was negative.

Atropine was instilled in her eyes for refraction and after having been instilled for several days the vision in both eyes returned to 20/20 under the influence of the drug and remained after the effect has passed off. Her vision is now 20/20. Coincident with the return of normal



vision was the disappearance of the pain and burning sensation of the eyes and of the headaches.

I am at a loss to explain and account for the amelioration of the subjective symptoms, and the restoration of the visual acuity to 20/20. Could it have been due to the atropine, which was instilled for three days for diagnostic purposes and refraction? No, I don't think so. I think it was purely coincidental. Of course the psychic influence of having something done, together with the physiological rest might account for the disappearance of the subjective symptoms, but I hardly think these factors could bring her vision from 20/40 to 20/20. And surely a rest of only three days could not bring about such a permanent restoration of visual acuity, because the vision is still 20/20. Now, was the vision really 20/40 on the first examination or did I make a mistake. In this case the vision was taken by two people and the results compared.

The fundus change is, I think a *Retinitis Proliferans*. Manz describes this condition as a dense mass of connective tissue extending out into the vitreous from the retina and is at times attached to the papilla. He describes new blood vessels growing into the mass. The causative factor, he says, is either a foreign body or spontaneous hemorrhage due to tuberculosis, syphilis, nephritis, or some like constitutional diathesis. Vision is frequently greatly impaired, but according to Duane some retain surprisingly good vision. Weeks believes that the essential of the disease is the production of membranes out into the vitreous and that fibrinous exudation or hemorrhage must precede formation of those membranes. The disease is more common in young than in elderly people.

Now there is a possibility of this being a remnant of the hyaloid artery. But its width after it approaches the temporal half of the retina is a little broader than I think is consistent with the remains of the hyaloid artery. Then again the structure is not as fibrous and organized as you would expect the artery to be. One would expect to find a posterior polar cataract with the remnant of the artery, which we do not find in this case.

In this case the proliferation is rather membranous and non vascular than fibrous and vascular. There is apparently very little visual disturbance in this case other than a peripheral contraction of the form field which of course may not be due to this condition.

## VACCINE THERAPY THE MOST RATIONAL AND EFFECTIVE METHOD OF PREVENTING WHOOPING COUGH IN PUBLIC INSTITUTIONS.

By CHARLES JAMES BLOOM, M. D., B. Sc., Professor of Pediatrics, Graduate School of Medicine, The Tulane University of Louisiana; Chief Visiting Pediatricist Charity Hospital; Senior Pediatricist, Lying in Hospital; Visiting Pediatricist Hotel Dieu and Memorial Home; Junior Pediatricist Touro Infirmary.

AND

DR. GEORGE J. DE REYNA, Junior Pediatricist Lying in Hospital; Lecturer in Pediatrics, The Graduate School of Medicine, The Tulane University of Louisiana.

During the month of April, 1919, five cases of Whooping Cough were noted in the St. Vincent's Foundling Orphan Asylum. The cases in question were discovered in different wards, in the second stage of the disease. Practically all of the children had been subjected to infection. Promptly these children were isolated and an attempt was made to limit the further spread of this serious malady.

The writers appreciating the prophylactic virtue of the Pertussis vaccine decided to use this method, in the hope of eradicating this disease. In order to impress the value of the results obtained, it might not be amiss to give the readers a brief mention relative to this institution. This Asylum cares in the main part for the greater number of illegitimate children born in this institution, city, and in neighboring parishes. A large percent of those admitted are marasmic; others show different manifestations of malnutrition; and many give signs of congenital lues. The resident population is constantly changing inasmuch as many of the children are adopted, and the older ones are sent to different institutions for further care and permanent abode. The dietetic consideration is seriously wanting, and even though some children have remained in this institution for a period of three or four years they are more or less under par.

The institution is over crowded and the buildings are old and antiquated. These facts are given not in the way of disparagement but simply to demonstrate forcibly that even with serious handicaps in the way of birth and environmental factors—these children did not contract Whooping Cough although they were intimately exposed to this disease.

## THE CASES.

Under 1 mo. (youngest case 10 days).....	13 cases
1 mo.—6 mos.....	50 cases
6 mos.—1 yr.....	34 cases
1 yr.—6 yrs.....	107 cases
	—
	Total.....204

*The Vaccine.*—The vaccine employed in this institution was a mixed stock vaccine, (recently prepared within one month.) No preservative was used in the manufacture of same. Each c. c. of this vaccine contained 5,000,000,000 Bordet-Gengou Bacilli and 3,500,000,000 Influenzae Bacilli.

*The Method.*—Infants under 6 months,  $\frac{1}{4}$  c. c., 3 doses, on alternate days. Infants from 6 months to 1 year,  $\frac{1}{2}$  c. c., 3 doses, on alternate days. Children from 2 to 6 years,  $1\frac{1}{4}$  c. c., 3 doses, on alternate days.

*The Results.*—In previous years not less than fifty percent of the entire number of children living in this institution contracted Whooping Cough. From the first week in May 1919, to the first of January, 1920, *there was not a new case of Whooping Cough noted in this institution.* It is evident that the prophylactic use of this vaccine has untold possibilities in the prevention of Whooping Cough in asylums, schools and public institutions, and in the limiting of disastrous epidemics.

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## DEMONSTRATION OF PLATES MADE WITH THE BUCKY POTTER DIAPHRAGM.\*

By DR. E. C. SAMUEL and DR. E. R. BOWIE.

Our purpose this evening is merely to show to you some plates which demonstrate the advantages of the Bucky diaphragm, principally as applied to radiography of the spine and other parts of the body where there has been great difficulty in obtaining clear detailed radiographs.

Our difficulty in these regions has previously been due to the production of secondary radiation in the tissues. It is a simple matter to get clear, sharp, detail in the thinner portions of the

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\* Read before the Orleans Parish Medical Society, February 14, 1921.

body, such as the extremities, but when it comes to the deeper structures, both osseous and visceral, we have had this problem of secondary radiation to contend with. These secondary radiations arise in the tissues themselves as a result of the passage of the primary X-ray. We have thus the scattered secondary radiation, produced in the tissues and coming off at all angles, thus obscuring the clear detail which we get from the normal direct way.

The means taken to eliminate this secondary scattered radiation is the apparatus known as the Bucky diaphragm. This consists in interposing between the plate and the patient a moving grid, the grid is formed of very thin strips of lead, arranged parallel to each other, and equally spaced by thin strips of wood. The production of the secondary scattered radiation in the tissues is not thus prevented, but they are merely eliminated from any effect upon the film, as only the direct rays coming off radially from the target of the tube are permitted to pass through the spaces of the grid, the scattered rays strike the lead strips and are stopped.

During the exposure, commencing the fraction of a second before the rays are given off, and continuing a fraction of a second after their interruption, this grid moves across the plate. Of course, this grid as now developed, eliminates the scattered radiation in but one direction, and we thus fall short of the ideal, were it possible to have another grid moving at right angles to the first one. Under present conditions the length of exposure is increased from four to five times over that necessary when not using the Bucky diaphragm. This will give you an approximate idea of the comparatively small amount of direct parallel rays which make their exit from the body. Were we to have a second grid, the time would be still further increased to probably double this time. In addition we would have the mechanical difficulties which are inevitable with increasing complication of our apparatus.

For all practical purposes, the results are so greatly superior with the present apparatus, to those previously obtained, that for the time being we can be content.

As has been previously mentioned, the greatest field for the Bucky diaphragm principle is in radiographic work about the spine. By its use we are able to equal in the dorsal spine the results which we have previously exceptionally obtained in the lumbar spine. In lateral views of the spine as well, there is the



same vast improvement as is seen, for instance, between a plate made with and without an intensifying screen. It is true that with selected patients, and by means of careful diaphragming, taking small areas of the spine at a time, we have been able previously, to obtain satisfactory plates of the vertebra, but here we have an apparatus, by the use of which, at one exposure we can cover an area 14x17 inches, with perfect detail to the limits of the plate. It is needless to call your attention to the advantage of having a plate of this size with its wealth of detail, not only of the spine, but of the surrounding tissue, to a series of from four to five small sectional radiographs of the same area. In previous work, where we depend upon careful diaphragming to give us satisfactory results, it was only by means of very severe compression that we were enabled to obtain our results; this was at times impossible for the patient, and at all times a discomfort. With the Bucky diaphragm, the necessity for compression is entirely eliminated. It will be noted in the radiographs presented that there is more magnification than usually noticed; this is due to the fact that they are made at a greater distance than we have been accustomed to using.

In addition to its value in giving us bony detail we have been greatly aided in the demonstration of the kidneys. It is true that the satisfactory demonstration of the kidney outline, at least the lower pole, no longer offers any particular difficulty to the Radiologist, but in order to obtain a satisfactory radiograph to cover the entire urinary tract, it has been necessary to make at least two radiographs, some Radiologists even making four to six, and this too, with the disagreeable compression feature, has been a prerequisite. We think it will be agreed that it is desirable, when possible, to demonstrate the entire urinary tract on one plate, made under the same exposure, and developed at one time. In cases where a pyelogram is made, it is very desirable to have the entire tract on one plate.

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**PROCEEDINGS OF THE STAFF OF TOURO INFIRMARY****(HELD AT TOURO ON FEBRUARY 9, 1921.)**

(Continued)

DR. E. S. HATCH. My excuse for speaking about syphilitic joint disease is on account of a case I was asked to see by our Directress of Nurses during the last six weeks.

This patient had been seen by a member of the staff, skiagraphs made, and the wrist-joint put up in splints. The patient had not improved under this treatment and I was asked to see her several weeks later. A series of skiagraphs showed marked osteoperiostitis of the carpal bones and of the radius. This patient was immediately put on mixed treatment; with stimulating local treatment and she began to improve rapidly. She has since had one dose of Salvarsan and at the present time is symptomatically well.

Each year, this diagnosis is made in a larger proportion of our cases at the Orthopedic Clinic of Touro Infirmary. It is rare that a patient is referred with a probable diagnosis of luetic disease, these cases usually being classed as rheumatism, infectious arthritis, or tuberculosis. There is apparently no definite pathological picture of syphilis. Ely says "the appearance of syphilis, tuberculosis, and atrophic arthritis and many other arthritic conditions is precisely the same." We make this diagnosis, therefore, tentatively by exclusion and then prove it mainly by the skiagraphs. According to Wegner, the usual order of joint involvement is as follows:

(1) Distal end of femur, (2) Distal end of tibia and fibula, (3) Proximal end of tibia, (4) Proximal end of femur, fibula and humerus.

In the differential diagnosis, the history plays an important part and the fact that the patients do not know of ever having had syphilis, should not be given too much weight. The obstetric history of married women should be looked into. Multiple joints are often affected and the subjective symptoms are not in proportion to the joint involvement. Pain at night is a common symptom.

In my experience, the Wassermann reaction has been negative in at least half of our cases and I am in the habit of having both the Wassermann and Luetin tests made on all cases and quite frequently when the Wassermann is negative, the Luetin is positive. The joint manifestations of the disease usually take place

in the late secondary and tertiary stages. The X-ray findings are usually well shown in the bones entering into the joint and are either periostitis or osteoperiostitis. I might mention three cases as illustrative of what I mean by the fact that these cases often go unrecognized.

First: Lady, aged 44, was seen complaining of multiple joint pain. First noticed pain last summer in the cervical region. Has been to Mt. Clemens and seen by many doctors. All examinations including Wassermann reactions negative. Skiagraph made by me showed typical arthritis of knee, ankle and elbow, and hands, especially noticeable in the phalangeal joints.

Another case referred by Dr. Lemann: A patient who had suffered severe empyema and later developed pain and stiffness in the right knee. This patient showed a suspicious periostitis of the upper end of the right tibia and fibula, and a positive Wassermann reaction.

A third case seen recently complaining of multiple joint pains who had been carefully examined by several physicians, radiographs of teeth and all ordinary examinations including Wassermann reaction were negative, but the idea had apparently never suggested itself to her physicians to make a radiograph of one of the painful joints. Skiagraph made by me shows marked periostitis of the metacarpal and phalangeal bones. This patient, as well as the others, is improving rapidly under mixed treatment. I feel that in all cases of doubtful joint disease, the question of syphilitic infection should be given due consideration, and, if necessary, the use of mixed treatment as a therapeutic test is certainly indicated.

DR. ISIDORE COHN—(Discussion). In the Surgical Clinic, we have had an opportunity to study a great many cases. In 1917, I reported the study of 50 cases of syphilitic bone disease of the shaft studied in the clinic. Certain things impressed us very much. Negative history of syphilis of patient is of no value. A history of trauma has been present in possibly half of our cases. Pain at night as a characteristic manifestation is not borne out in our experience. One thing has been rather important; that is, persistent localized pain not associated with acute inflammatory manifestations and in the absence of fracture, suggests syphilitic bone disease. Moreover, positive Luetin when iodide of potassium has not been given has been of value. Dr. Lanford did many of the tests.

With positive X-ray findings and clinical history of pain along the shaft of one of the long bones, these are suggestive of syphilitic bone disease. A negative Wassermann has been found in at least 50 per cent of the cases. There is no single characteristic X-ray finding in syphilitic bone disease. We have found changes varying from a slight cortical osteitis, proliferative, to a general thickening of the entire cortex. In some instances, the cortical thickening has been so great as to mask the normal appearance of the medullary canal. In other instances, we have noted a central area of rarefaction which might have been mistaken for an osteomyelitis of acute origin had we not had the history and negative blood findings. As a result of experimental work, we prefer to speak of the proliferation on the cortex as a cortical osteitis rather than a periostitis, the reason being that we do not believe that the periosteum possesses osteogenetic properties but that it is rather a fibrous limiting membrane which has the power of other fibrous tissue but not that of bone regeneration.

Iodide of potash and mercury have given us better results in the treatment of these cases than salvarsan.

DR. LEMANN—(Discussion). I felt quite sure that the joint trouble in the patient whom I referred to Dr. Hatch was an infectious arthritis following her empyema. It is interesting to know that syphilis can produce a joint condition so closely simulating infectious arthritis. Certainly this experience was a lesson to me.

DR. J. T. O'FERRALL—(Discussion). It seems to me Dr. Hatch laid particular stress at first on the difference in the joint changes and then he seems to lay more stress on the shaft of the bone. Since I had the opportunity to see a great many pictures with Mr. Walter Dodd in Boston, and heard him say he could not tell the difference between tubercular joint disease and syphilitic joint disease, I have long since come to the same conclusion. I do agree with Dr. Hatch's diagnosis of syphilis more often made from changes in the shaft.

Pictures shown here principally point to diagnosis of periostitis and changes in the shaft rather than joint changes. I have seen a good many cases recently,—one hip and one wrist in which joint changes, in my opinion, could not be differentiated between syphilis and tuberculosis. Patients are, however, clearing up under mixed treatment. Wassermann negative. No evidence of syphilis other



than joint changes which are not characteristic. With thickening of the cortex of the shaft, I immediately became very suspicious of syphilis.

DR. A. NELKEN. A case of Bone Syphilis which Dr. Hatch and I happened to be treating at the same time is very instructive.

This young man had marked syphilophobia. Before marriage, Spinal Wassermann and Blood Wassermann negative. Subsequent Blood Wassermann negative. He consulted Dr. Hatch for pain in the knee; radiograph showed no disease of the knee-joint but a condition in the bone below the knee suggestive of lues. Because of the doubt as to his history, I decided to give him therapeutic test. He was put under mixed treatment for six weeks at the end of which time a second picture by Dr. Hatch showed that the condition seen in the first picture had disappeared. Patient was then put under active anti-syphilitic treatment. This case is instructive, I believe, in showing the superiority of a combination known as "mixed treatment" over the protoiodide in the treatment of syphilis, since this patient had been taking protoiodide for an indefinite period.

I have had a wide experience with the luetin test, but have discarded it now for several years. I think the originator of the test, Noguchi, himself, has ceased to recognize it as a diagnostic agent in syphilis. I think that too much stress cannot be laid on the mistake of relying too strongly upon the Wassermann reaction in the diagnosis of syphilis. A great many of us are inclined to lean too heavily on the laboratory in order to make diagnoses anyway. Certainly, the negative Wassermann in the presence of any clinical evidence of syphilis can be discarded and I have learned not to lay too much stress upon the positive Wassermann. One point in the discussion of the Wassermann which must not be lost sight of is that the technique of each laboratory varies and before we can form our conclusions, we must have some idea of the technique of the laboratory making the report.

DR. ISIDORE COHN. In answer to Dr. Nelken's statement that salvarsan has, in some instances, after one dose caused a clearing up of the appearance of the bone disease in a few weeks, in our experience this has not been borne out. In some instances, we have given as many as four doses without noting a disappearance of the mass on the surface of the bone or relief of pain. After

giving large doses of iodide of potash and mercury, the pain has been relieved, and the mass has disappeared, and the patient found himself greatly relieved. It has taken longer, in our experience, than six weeks for bone lesions to heal. The normal appearance of bone which would not give any suggestion of a previousluetie bone disease has been found after periods of one and two years. The Luetin reaction has been of service in confirming a diagnosis which previously had been based on clinical manifestation—X-ray findings, and after these three evidences have been correlated and the patient treated, relief from symptoms has resulted. For that reason, we have not discarded the Luetin.

DR. J. A. LANFORD. It is a well-known fact that syphilitic bone conditions give a relatively low percentage of positive Wassermanns—why, I am not able to state, unless it is due to the fact that only a small amount of tissue change has taken place, resulting in the outpouring of a minimum quantity of syphilitic toxin and, therefore, only a small quantity of antibodies is produced. However, in practically all instances, the luetin test is positive, but, because it is affected by certain drugs,—particularly potassium iodide, the interpretation of the test is very difficult and requires care and experience. In very active syphilitic bone lesions, accompanied by destruction of tissue, the Wassermann reaction is most often positive. I recall a condition of this character in a patient from the Pediatric Clinic. This child had a lesion of the left radius which was characterized by enlargement, necrosis and ulceration and discharge through the skin. The X-ray examination showed distinct changes in the periosteum and endosteum, and the Wassermann was strongly positive. So, from this result, we are forced to admit that an active bone lesion produced by the “*trepone*ma pallida” gives a positive Wassermann just as active syphilitic lesions in other tissue.

DR. E. S. HATCH—(Discussion). I agree with Dr. Cohn that Luetin reaction is of undoubted value. It is, of course, not positive but together with positive X-ray findings, it certainly has a place.

I fear that I did not make myself clear as to the difference in the skiagraph findings shown in joints and bones and in answer to Dr. O’Ferrall, would say that I believe the hereditary cases show the most typical joint conditions. These are described by Fraenkel

as "heavy, broad, homogeneous, irregularly jagged band-like shadow at the epiphyseal diaphyseal junction, well separated from the diaphysis and jagged toward the epiphysis. Beneath this is a band showing increased penetration by the rays which gives the impression of a break in continuity of the shaft." In the acquired type, we get various findings, the most constant being a periostitis of the bones entering into the joint. These are fusiform sub-periosteal overgrowths and sometimes we see the so-called "Codman Blister."

DR. L. H. LANDRY. We have a very interesting little case in the hospital that I did not bring down for exhibit, because the young lady is quite nervous. The chief interest in the case centers on the diagnosis. We obtained a history of a popliteal tumor of three years duration, gradually getting larger until now the mass has attained the size of a hen's egg. The tumor mass was so painful that it was impossible to properly palpate it. The leg muscles showed considerable atrophy and the child was unable to put the heel to the ground. There was also a history of a febrile attack shortly before the appearance of the mass; the father claims that cerebrospinal meningitis was prevalent at the time she had her fever and in view of the muscular atrophy, it was suggested that this attack might have been meningitis. She was sent here with a probable diagnosis of neuroma; this diagnosis was submitted largely because the tumor mass was so painful, preventing the patient from straightening the limb. We considered the possibility of a popliteal lipoma; aponeurotic sarcoma, hemorrhagic cyst. Under anesthetic, we found the mass freely movable on the inner aspect of the popliteal region, with no bony connection. We excluded lipoma, because the growth was confined to the inner aspect of the popliteal space, internal to the semimembranous and semitendinous tendons. For the same reason we excluded a neuroma. The length of time it took to attain the present size was against the possibility of aponeurotic sarcoma in a child. An incision was made over the mass and it was found to be incorporated in the lower end of the sartorius muscle, close to its insertion; the mass was completely encapsulated and easily separated from the surrounding structures. The internal popliteal nerve was found intimately connected to the tumor mass, which accounted for the acute pain she experienced on palpation. This was separated and the tumor mass removed. The sartorius had to be severed com-

pletely to remove the mass and the distal end was sutured to the semimembranous tendon.

The tumor was sectioned and found to contain nothing but a large well organized clot, and sent to the pathological department for further study.

DR. J. A. LANFORD. The tumor was about the size of a guinea egg, fairly well encapsulated, dark reddish in appearance, and of a fairly firm consistency. On sectioning, it offered some resistance to the knife and gave a sensation of grittiness in places. The cut surface was uniformly red in color, some areas being of a darker hue, marking the channel whereas the lighter bands were the wall of the vessels. In the wall of these vessels, we found a few areas of calcification which are sometimes present in these neoplasms. Microscopically, the structure was found to be a simple angioma of the blood vessel type. These growths are benign in character in that they would not produce secondary growths elsewhere, but they will continue to grow and destroy the structures in which they are located, and will return unless every vestige has been removed.

The patient had made a very good recovery, having no pain since the operation and is now ready to leave the institution in the next two or three days.

DR. E. C. SAMUEL. I wish to show tonight, some plates made by the aid of the Bucky diaphragm which we have just received. By means of this apparatus, we are able, to a large extent, to eliminate the secondary radiation which has been a source of great trouble in making large plates of such portions of the body as the lumbar region. We are able with this method to cover completely a 14 x 17 plate getting at the extreme edges of the plate the same wealth of detail which we would formerly get over a small area by careful diaphragming. I wish to call special attention to the soft tissue detail such as the kidney outline, even showing the upper pole of the kidney, which we rarely see. Here is a skull plate (picture shown) with the same clear detail throughout that we have gotten only exceptionally. We have again a lateral view of the dorsal spine which Dr. Hatch will agree is very difficult to obtain. Another view is that of an A. P. dorsal spine, showing the vertebra clearly and distinctly. Again a lateral view of a dorsal spine, as well as some of the lumbar spine, in which can



be noted the clear detail of the sacrum and coccyx. Here we have a plate showing a large, coralliform stone in the right kidney, the detail here being a little indistinct, owing to the inability of the patient to hold her breath. The left kidney has been removed; therefore, we have no shadow on the left side. A great feature in the use of the apparatus is the ability to show the entire urinary tract of both sides of one plate. Here is one showing a peylogram of the kidney. These few samples of the work which we have hastily gotten together for your consideration will, I think, be sufficient to give you some idea of the range of its application and the information to be gained.

### ANALYSIS OF HOSPITAL SERVICE.

(Representing all discharges in December, excepting admissions prior to July 1st, 1920.)

DEPARTMENT	Total	Cured	Improv.	Stat.	DIED 48 hrs.	TOTAL Dead.
Ear, Nose and Throat.....	108	85	17	5	0	1
Eye .....	10	1	7	2	0	0
Gastro-Intestinal .....	22	4	10	8	0	0
Gynecological .....	92	47	40	4	1	1
Medical .....	57	8	34	10	1	5
Neurological .....	21	1	9	10	0	1
Obstetrical .....	44	35	5	3	0	1
Newborn .....	29	29	0	0	0	0
Stillborn .....	3	0	0	0	0	3
Orthopedic .....	14	1	7	6	0	0
Pediatric .....	14	2	6	2	1	4
Skin .....	1	0	1	0	0	0
Surgical .....	146	79	50	8	1	9
<b>Total.....</b>	<b>561</b>	<b>292</b>	<b>186</b>	<b>58</b>	<b>4</b>	<b>25</b>

DEPARTMENT	INFECTIONS		DIAGNOSIS		Addl.	Tent. not given	Consul- tations
	Instl.	On Adm.	Agree	Disagree			
Ear, Nose and Throat ..	..	..	108	0	0	0	0
Eye .....	..	..	9	0	1	0	0
Gastro-Intestinal .....	..	..	17	3	0	2	0
Gynecological .....	1	..	73	8	11	0	4
Medical .....	..	..	40	11	5	1	8
Neurological .....	..	..	13	1	2	5	8
Obstetrical .....	..	..	40	1	2	1	1
Newborn .....	..	..	29	0	0	0	0
Stillborn .....	..	..	3	0	0	0	0
Orthopedic .....	..	1	14	0	0	0	0
Pediatric .....	..	..	11	2	0	1	2
Skin .....	..	..	1	0	0	0	0
Surgical .....	4	6	133	10	3	0	4
<b>Total.....</b>	<b>5</b>	<b>7</b>	<b>491</b>	<b>36</b>	<b>24</b>	<b>10</b>	<b>27</b>

## BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Secy-Treas.

The Scientific Program for the approaching meeting of the State Medical Society, to be held in New Orleans April 19th, 20th and 21st, 1921, is as follows:

### FIRST DAY, TUESDAY, APRIL 19, 1921.

#### Morning Session, 9 o'clock.

1. Call to Order.....Dr. H. Dupuy, New Orleans,  
President, La. State Med. Soc.
2. Invocation .....Rev. F. D. Sullivan, S. J.,  
Dean, Loyola Dental School.
3. Address of Welcome.....Hon. A. J. McShane,  
Mayor of New Orleans.
4. Welcome on behalf of the Local Pro-  
fession .....Dr. S. M. Blackshear,  
Pres., Orleans Par. Med. Soc.

#### SECTION ON GENITO-URINARY AND RECTAL DISEASES.

DR. H. W. E. WALTHER, New Orleans, Chairman.

1. "Treatment of Urethritis, with Re-  
spect to Some Important Compli-  
cations" .....Dr. M. H. Foster, Alexandria.
2. "Factors that Make for Safety in  
Prostatectomy" .....Dr. A. Nelken, New Orleans.

#### SECTION ON NERVOUS DISEASES.

DR. J. A. O'HARA, New Orleans, Chairman.

1. "A Statistical Study of Three Thou-  
sand Cases of Mental Diseases".....Dr. Hy. Daspit, New Orleans.  
To Open Discussion.....Drs. L. L. Cazenavette and  
J. A. O'Hara, New Orleans.
2. "Epidemic Encephalitis".....Dr. L. V. Lopez, New Orleans.  
To Open Discussion.....Dr. C. S. Holbrook, N. O., and  
Dr. E. M. Connely, N. O.
3. "Some Observations as to the Prog-  
nosis in Insanity".....Dr. C. V. Unsworth, N. O.  
To Open Discussion.....Drs. Hy. Daspit and B. F. Gal-  
lant, New Orleans.

#### Afternoon Session, Two o'clock.

#### SECTION ON PEDIATRICS.

DR. C. J. BLOOM, New Orleans, Chairman.

1. "Acute Ileo-Colitis in Children".....Dr. M. S. Picard, Shreveport.
2. "Neglected Teeth of Children".....Dr. J. Ross Snyder,  
Birmingham, Ala.
3. "Needed Hygiene".....Dr. Maude Loeber, N. O.

#### SECTION ON EYE, EAR, NOSE AND THROAT INCLUDING STOMATOLOGY.

DR. F. C. BENNETT, Monroe, Chairman.

1. "Recent Progress in Ophthalmology".....Dr. C. A. Bahn, New Orleans.  
To Open Discussion.....Dr. John Scales, Shreveport.

2. "Nerve Blocking Anesthesia".....Dr. W. M. Johnson, N. O.  
To Open Discussion.....Dr. R. C. Lynch, New Orleans.
3. "Diagnosis and Susceptibility in Hay  
Fever".....Dr. Wm. Scheppegegel, N. O.  
To Open Discussion.....Dr. Jos. Martin, New Orleans.
4. "Removal of Foreign Bodies from  
Cornea and Conjunctiva".....Dr. H. D. Bruns, New Orleans.  
To Open Discussion.....Dr. T. J. Dimitry, N. O.

**SECOND DAY, WEDNESDAY, APRIL 20, 1921.**

Morning Session 9 o'clock.

**SECTION ON RADIOLOGY.**

DR. L. J. MENVILLE, New Orleans, Chairman.

1. "Some Interesting Gastro-Intestinal  
Cases" .....Drs. L. A. Fortier and T. T.  
Gately, New Orleans.
2. "Radium Therapy".....Dr. A. Henriques, N. O.
3. "Situs Inversus".....Dr. L. J. Williams, B. Rouge.

**SECTION ON GYNECOLOGY AND OBSTETRICS.**

DR. H. W. KOSTMAYER, New Orleans, Chairman.

1. "Ante-Partum Hemorrhage"—Treat-  
ment .....Dr. J. C. Grémillion,  
Alexandria.
2. "Acute Diffuse Gonorrheal Periton-  
itis, without Tubal Rupture".....Dr. M. J. Gelpi, New Orleans.
3. "Cancer Prophylaxis".....Dr. J. C. Willis, Shreveport.
4. "Some Refinements in Hysterectomy  
with Special Reference to Cer-  
vix".....Dr. S. M. D. Clark, N. O.

**SECTION ON GENERAL SURGERY.**

DR. G. M. G. STAFFORD, Alexandria, Chairman.

1. "Kidney Surgery under Local Anes-  
thesia".....Dr. C. W. Allen, New Orleans.
2. "Some Fractures of the Base Treated  
by Repeated Spinal Punctures".....Dr. L. B. Crawford, Patterson.  
Afternoon Session, 2 o'clock.
3. "Report of a Case of Tetany after the  
Third Partial Thyroidectomy".....Dr. H. B. Gessner, N. O.
4. "Factors Influencing Mortality in  
Surgery of the Thyroid Gland".....Dr. J. M. Batchelor, N. O.
5. "The Diagnosis and Treatment of  
Perforating Gastric Ulcer".....Dr. J. L. Wilson, Alexandria.
6. "Surgery of the Gall-Bladder and  
Biliary Duets".....Dr. J. A. Danna, New Orleans.
7. "The Fundamental Properties and  
Therapeutic Uses of Radium".....Dr. C. A. Voss, New Orleans.
8. "Treatment of Empyema".....Dr. F. W. Parham, N. O.  
To Open Discussion.....Dr. M. Bradburn, New Orleans.
9. "Cholecystostomy versus Cholecystec-  
tomy Especially in the Aged".....Dr. E. D. Martin New Orleans.  
To Open Discussion.....Dr. Alfred C. King, N. O.
10. "How Apothetin compares with other  
Agents used in Spinal Analgesia,  
with Special Reference to a Near  
Accident in a Case of Prostatec-  
tomy" .....Dr. P. J. Gelpi, New Orleans.





**Special Evening Session, 8 o'clock.**

**SECTION ON PUBLIC HEALTH AND SANITATION.**

DR. E. F. BACON, New Orleans, Chairman.

1. "Drug Addiction and Its Relation to Public Health" .....Dr. M. W. Swords, N. O.
2. Title unannounced .....Dr. H. R. Crohurst,  
Washington, D. C.

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I wish to call your attention to the fact that on Thursday evening there will be a Special Session of the Scientific body devoted entirely to Public Health and Sanitation.

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The Post-Graduate Committee of the Louisiana State Medical Society has arranged for the following very interesting program:

During one week previous to the State Medical Society meeting (April 11th to 18th), and the week following the meeting, (April 25th to May 1st), for post-graduate work, every member of the Louisiana State Medical Society will be entitled to the privilege of this course to be conducted by the Graduate School of Medicine, Tulane University, and the Loyola Post-Graduate School of Medicine.

These schools have thrown open their doors to the members of our Society, at this time, and it will only be necessary for a member to show his 1921 Membership Card to gain admission to their valuable courses.

During the week of the meeting, upon the days of April 18th, 22nd and 23rd, Special Clinical features are being arranged at the various Institutions of the City of New Orleans whereby members of the State Medical Society, attending our meeting, will be given the unusual opportunity of witnessing some of the most valuable Clinics held in the South. The exact details of these Clinical programs will be announced in our official program.

We hope all the members of our Society, especially those in the rural districts, will avail themselves of this opportunity and show their appreciation to the members of this Committee and the La. State Medical Society, for arranging these additional features for our State organization. It behooves all, therefore, who need Post-Graduate work, to avail themselves at this time of these opportunities.

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The following list of Committees is given out so that the Chair-

man and members of these Committees should know that the Louisiana State Medical Society expects a report from them at the coming meeting:

**STANDING COMMITTEES**

**Committee on Scientific Work.**—Dr. P. T. Talbot, chairman; Dr. A. Henriques, New Orleans; Dr. S. M. Blackshear, New Orleans.

**Committee on Public Policy and Legislation.**—Dr. Clarence Pierson, chairman, Alexandria; Dr. Homer Dupuy, New Orleans; Dr. P. T. Talbot, New Orleans; Dr. I. Cohn, New Orleans.

**Committee on Publication.**—Dr. P. T. Talbot, chairman, New Orleans; Dr. J. E. Knighton, Shreveport; Dr. Amédée Granger, New Orleans.

**Budget and Finance Committee.**—Dr. H. W. E. Walther, chairman, New Orleans; Dr. J. B. Larose, New Orleans; Dr. T. A. Roy, Mansura; Dr. V. F. Fuchs, New Orleans; Dr. E. M. Ellis, Crowley.

**Committee on Medical Education.**—Dr. L. R. DeBuys, chairman, New Orleans; Dr. J. E. Knighton, Shreveport; Dr. C. W. Allen, New Orleans.

**Committee on Memorial.**—Dr. W. H. Seemann, chairman, New Orleans; Dr. J. A. O'Hara, New Orleans; Dr. J. N. Thomas, Pineville; Dr. A. E. Fossier, New Orleans; Dr. R. G. Holcombe, Lake Charles

**Committee on Medical Defense.**—Dr. P. T. Talbot, chairman, New Orleans; Dr. J. C. Willis, Shreveport; Dr. Hy. Leidenheimer, New Orleans.

**SPECIAL COMMITTEES**

**Committee on Public Health.**—Dr. T. A. Roy, chairman, Mansura; Dr. Louis Abramson, Shreveport; Dr. M. W. Swords, New Orleans.

**Committee on Health and Public Instruction.**—Dr. R. B. Wallace, chairman, Alexandria; Dr. R. Bernhard, New Orleans; Dr. R. O. Simmons, Alexandria; Dr. P. Graffagnino, New Orleans.

**Committee on Cancer Research.**—Dr. W. H. Harris, chairman, New Orleans; Dr. J. C. Willis, Shreveport; Dr. A. Henriques, New Orleans.

**Committee on Hospitals.**—Dr. J. W. Newman, chairman, New Orleans; Dr. C. A. Weis, Baton Rouge; Dr. R. B. Harrison, New Orleans; Dr. L. J. Menville, New Orleans.

**Committee on Hospital Standardization.**—Dr. R. O. Simmons, chairman, Alexandria; Dr. J. C. Willis, Shreveport; Dr. H. W. Kostmayer, New Orleans; Dr. Louis Abramson, Shreveport; Dr. J. A. Estopinal, New Orleans; Dr. C. P. Gray, Monroe.

**Committee on Industrial and Economic Relations to Medicine.**—Dr. I. Cohn, chairman, New Orleans; Dr. A. E. Fossier, New Orleans; Dr. W. H. Block, New Orleans; Dr. Geo. F. Roeling, New Orleans.

**Committee on Resolutions.**—Dr. T. A. Roy, chairman, Mansura; Dr. B. W. Smith, Franklin; Dr. Louis Abramson, Shreveport.

**Committee on Health Problems in Education.**—Dr. A. A. Herold, chairman, Shreveport; Dr. G. C. Antony, Tioga; Dr. A. L. Whitmire, Orleans; Dr. H. P. St. Martin, Houma; Dr. S. L. White, Ruston.

**Committee to study Drug Addiction.**—Dr. W. H. Seemann, chairman, New Orleans; Dr. Hy. Daspit, New Orleans; Dr. R. M. Van Wart, New Orleans; Dr. A. L. Levin, New Orleans; Dr. C. V. Unsworth, New Orleans.

Dr. A. E. Fossier, New Orleans, La., Chairman of the Committee on Arrangement for the American Medical Association Convention in New Orleans, 1920.

The officers and members of the Louisiana State Medical Society should feel congratulated on being able to have secured the services of such an energetic and hardworker as Dr. J. J. Wymer, as Chairman of the Arrangement Committee for the approaching meeting.

We feel quite sure that with his past record of accomplishments we can look forward to an unusual amount of entertainment and social arrangement for the visiting members of our profession.

The House of Delegates of the Louisiana State Medical Society will be called to order on Monday morning, April 18th, 1921, at 9 o'clock, in the Hutchinson Memorial Building, Tulane Medical College, 1551 Canal Street, New Orleans.

The President of our Society, Dr. Homer Dupuy, has asked to have it announced that all meetings of the House of Delegates, also all Scientific Sessions of the Convention, will be called to order *ON TIME*, as specified in the program. Your kind co-operation in this regard is earnestly requested and the Delegates and Essayists should take special cognizance of this fact so as to be *ON TIME* and not delay the meetings.

As you will observe, we have a very large program and it will be only by strict adherence to time limits of papers and discussions, and by opening sessions punctually, that we will be able to complete same.

#### **PLAN OF ENTERTAINMENT.**

**First Day, April 19, 1921.**

**Entertainment, Twelve o'clock.**

Luncheon, Loyola Post-Graduate School of Medicine.  
(Corner Villere and Tulane Avenue, opposite Charity Hospital.)

**Entertainment, Evening, Eight o'clock.**

A Stag Frolic—By the Committee.  
Theatre Party for the women guests and women members.

**Second Day, April 20, 1921.**

**Entertainment, Twelve o'clock.**

Luncheon, by the Tulane College of Medicine, in the Hutchinson Memorial, 1551 Canal Street.

Luncheon at the "Louisiane," for Women Members only of the State Medical Society.

**Entertainment, 4 to 6 p. m.**

Automobile Ride, with refreshments en route, for the visiting and resident guests—women members and the lady members of the Committee.

### **HOTELS**

Reservations can be made in advance by writing the following Hotels:

Grunewald, Mr. Geo. Weber, Manager.  
St. Charles, Mr. P. O'Shaunnessy, Asst. Manager.  
DeSoto Hotel, Mr. Vic. Lebeau, Manager.  
Monteleone, Mr. F. Kenney, Manager.  
Planters, Mr. H. A. Michel, Manager.  
Lafayette, Mr. Lyle Aschaffenberg, Manager.

### **HEADQUARTERS**

Tulane College of Medicine, 1551 Canal Street, Hutchinson Memorial. (Walking distance from any of the Hotels).

### **REGISTRATION**

Enter the basement of the building and register before going to the Meeting Hall, getting at the same time invitations to the functions arranged for your entertainment.

Ladies accompanying members will be required to register and wear the official badge of the meeting, in order to participate in entertainment arranged for them by the Committee.

### **MAIL**

All mail addressed in care of the Convention will be taken care of at the Registration office and a daily notice will be posted of letters received.

### **INFORMATION**

Any matter that you are not posted on can be explained at the registration office.

### **CLUBS**

The following Clubs have extended the courtesies of their home to all members of the Association, wearing the official badge and no admit card will be necessary:

The Elks Club, Elk Place, Near Canal.  
Chess, Checkers and Whist Club, Bourbon near Canal.  
(The old Cosmopolitan Hotel.)  
Young Men's Gymnastic Club, 224 N. Rampart Street.

(Signed) DR. J. J. WYMER,  
*Chairman Arrangement Committee.*

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Dr. W. T. Patton, Secretary and Treasurer of the Orleans Parish Eye, Ear, Nose and Throat Club, wishes to announce that there will be a Clinical Meeting, of that body, on Monday, April



18th, at 8 p. m., in the rooms of the Orleans Parish Medical Society, 1551 Canal Street, New Orleans. All members and guests of the State Medical Society are cordially invited to attend.

This meeting is to take place of the meeting announced in the last issue of the *JOURNAL* for Tuesday, April 19th.

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On March 10th, 1921, there was an organization of the Parishes of St. Charles, St. John, and St. James, into a Tri-Parish Medical Society. The following officers were chosen:

Dr. L. T. Donalson, Sr., Reserve, President; Dr. L. Cheves Tebo, Reserve, Secretary-Treasurer.

Dr. L. A. Gaudin, of Convent, was elected President of the St. James Parish Medical Society. Dr. Geo. S. Bel, of New Orleans, La., Councilor for the Second District, Dr. Homer Dupuy, President of the Louisiana State Medical Society, and Secretary-Treasurer Dr. P. T. Talbot, were present to assist in the organization.

Dr. Bel delivered a Scientific and interesting talk on Pneumonia. His paper was enlightening and resulted in considerable discussion by the physicians present who expressed their gratitude and appreciation of the unusual opportunity afforded them in hearing such a Scientific paper by the essayist.

The meeting was well attended by representative men of that district and gives all promises of being able to continue as a progressive organization for Organized Medicine.

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At the Organization meeting of the Lafourche Valley Medical Society, held February 15th, 1921, it was accepted that the meetings of this Valley Medical Society would be held on the Second Tuesday of every third month, dating from February 15th, and time of meeting to be 11 a. m. Thibodaux, La., was chosen as the domicile of the Society and the first meeting in each year was entitled the Annual Meeting.

The following Committee on Constitution and By-Laws was appointed by the President: Dr. H. C. Dansereau, Labadieville, Dr. G. E. Trosclair, Thibodaux, and Dr. P. E. Parker, Bourg.

At the next meeting of this Society the following members will read papers: Dr. W. W. Pugh, Napoleonville; Dr. L. E. Meyer, Thibodaux; Dr. T. I. St. Martin, Houma, and Dr. C. M. Menville, Houma. *THE N. O. MED. & SURG. JOURNAL* was chosen as the Official Journal.

Physicians in Natchitoches Parish held a meeting recently for the organization of Natchitoches Parish Medical Society. Dr. P. W. Prudhomme, of Natchitoches, was elected Secretary-Treasurer.

Recently a meeting was held in DeRidder, La., for the reorganization of the Beauregard Parish Medical Society. Dr. S. O. Turner, of DeRidder, La., was elected Secretary.

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## NEWS AND COMMENT.

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RESOLUTIONS ADOPTED BY THE BOARD OF THE LOYOLA POST-GRADUATE SCHOOL OF MEDICINE on the occasion of the death on January 22, 1921, in the 37th year of his age, of Doctor Everard Mahler, an esteemed fellow-member.

Whereas, His life though brief has merited by his uprightness and integrity, the deep esteem of his fellow citizens, and

Whereas, His death is an irreparable loss and an unspeakable sorrow to his venerable parents, to his beloved and bereaved wife and children, and

Whereas, His passing away has left a void in the homes and the hearts of the needy, the sore distressed and the suffering, whom he befriended by his charity, comforted and served by his merciful aid and gracious and gratuitous professional services, and

Whereas, His demise has deprived the medical profession of a most valuable associate who has merited undying gratitude by his efficient, unswerving and indefatigable fidelity to duty in his professional practice and in the positions of trust and responsibility confided to him by the State Board of Medical Examiners and the Louisiana Medical Society, and

Whereas, In his death we bemoan the loss of a member of our Board of Directors of the Loyola Post-Graduate School of Medicine, to whom we feel most deeply indebted as to one who, looking forward with the largeness of aim and the disinterestedness of purpose of a truly great man to the greater good of humanity, identified himself with the school and at all times manifested an encouragingly active and hopeful interest in the development of this most promising institution, Therefore

BE IT RESOLVED, That we, as a token of our gratitude and a mark of our esteem, approve and adopt this brief summary of his life, his sterling worth and valuable services as a citizen, as son, a husband, a father, a friend, a professional man, a member of our Board of Directors, and that we order these resolutions spread on our minutes with the hope that his name and his memory be preserved in perpetuity, and

BE IT RESOLVED, That we tender to his venerable father and mother, to his devoted and sorrowing wife and children our most heartfelt sympathy and compassion in their grief and sadness, and that we order a copy of these resolutions to be sent to them by the Secretary

of the Board of Directors of the Loyola Post-Graduate School of Medicine.

Also the following, passed on March 2, 1921.

Whereas, It has pleased the Almighty in His infinite wisdom to take from our midst Dr. Philip Bergé, a member of the Faculty of this School; and

Whereas, Dr. Bergé was known to all by his sterling qualities as a man, his untiring efforts as a scientist, clinician, and as one who was ever interested in the welfare of the sick and afflicted; and

Whereas, His services were always at the disposal of the poor and needy, and he was ever ready to help a friend;

BE IT RESOLVED, That the death of Dr. Bergé is a distinct loss to this Community, and especially to the sick and needy who had been the beneficiaries of his kind and willing heart.

BE IT FURTHER RESOLVED, That this Board deeply mourns his loss and extends to his family its heartfelt sympathy in their bereavement.

THE FAIRCHILD SCHOLARSHIP. In accordance with joint action of the American Pharmaceutical Association, the American Conference of Pharmaceutical Faculties and National Association of Boards of Pharmacy, the Fairchild Scholarship is to be awarded on the basis of competitive examination to candidates who are high school graduates and who have successfully finished their first year's work in a School or College of Pharmacy, or Department of Pharmacy of a University, member of the American Conference of Pharmaceutical Faculties. Each school, college or department of Pharmacy is limited to two candidates.

HENRY AND DIANA L. GITTERMAN MEMORIAL FUND. A prize competition is announced by the Jewish Publication *Society of America* for the best essay or study upon the subject connected with the history of the Jews or their contributions to the general purposes of modern civilization. In connection with this general offer a prize of one thousand dollars is offered for an original study in the English language dealing with "Contributions of Jews to Hygiene." The competition is open to members of the faculties and to graduate students of universities in the United States. Professional schools and institutions of research (including hospital, municipal, state and federal laboratories) are considered to be in the same category as graduate schools of universities. Further details regarding the matter may be taken up with *The Jewish Publication Society of America*, 1201 North Broad Street, Philadelphia, on or before November 1, 1922.

**GLOVER'S CANCER SERUM.** Literature is being received by physicians about Dr. Glover's Cancer Serum. This is stated to be a serum from immunized horses and is claimed to have a specific action on every known type of cancer. The advertising offers to send the serum on receipt of price. While this seems to indicate that Glover's Research Laboratory, from which the literature comes, has received a permit from the U. S. Public Health Service licensing the interstate sale of the serum in the United States, no such license has been issued. (*Journal A. M. A.*, Jan. 1, 1921, p. 52.)

**UNION HEALTH CENTER.** The International Ladies' Garment Workers' Union has established a union health center in New York City, to guard and promote the health of the workers in the garment industry. This is the first health center to be established on an industrial basis and will serve some 100,000 workers.

**ADDITIONAL BEDS FOR AMERICAN EX-SOLDIERS IN HOSPITALS NEEDED.** The Surgeon General of the Public Health Service wants \$30,000,000 to provide additional beds for American ex-soldiers suffering from tuberculosis, mental diseases and other afflictions which can be charged to their service to their country. So far from declining the number of such patients is increasing at the approximate rate of 1000 per month, according to the Surgeon General, and it is expected that by the time the peak is reached in 1927 or 1929, from 30,000 to 35,000 beds will be required. An analysis of the 1919 War Risk Insurance hospital patients shows that 7586 were suffering from tuberculosis, 5680 from neuropsychiatric ailments and 5743 were undergoing general treatment.

**INCREASE IN GOITER.** Scientists in England and America have noted a great increase in reported cases of goiter, especially of the exophthalmic type. This is attributed to conditions of strain and worry existing during the war. Far more cases are reported among women.

**DEATHS FROM CHILDBIRTH IN 1919.** It is not generally known that approximately 18,000 American mothers died in childbirth in 1919. One of every ten children born alive in the registration districts of the United States in 1918 died before reaching the age of one year, more than half the deaths being preventable. Approximately a fifth of all the deaths in the United States last year



were of children under five. Practically seventeen million school children are without medical supervision. For a number of years there has been a gradual decline in the general death rate, accompanied by a similar decline of infant mortality due largely to better administration of the various Public Health organizations. The present program for caring for public health according to Dr. Cummings, the Surgeon General of the Public Health Service, includes industrial hygiene, rural hygiene, railway sanitation, the water supplies, the milk supplies, sewage disposal, campaigning against tuberculosis, malaria, venereal diseases, diseases of infancy and childhood, and it will undertake the collection of morbidity reports and organization of training or reserve forces for duty in emergencies.

**CHILD WELFARE IN MEXICO.** The first child welfare congress ever held in Mexico took place at Mexico City, January 2, 1921. Some 200 physicians from all parts of Mexico attended. It is stated that the mortality among the children in Mexico is startling and that in Mexico City alone 75 per cent of the deaths are of children under 16 years of age.

**BRITISH BIRTHS HIGHEST RECORDED.** According to the official report of the Registrar-General, births in England and Wales during 1920 reached the highest figure ever recorded, and the death rate was the lowest. The birth rate was 25.44 per thousand and the death rate was 12.4. The deaths of infants under one year were 80 per thousand.

**DEATHS OF PHYSICIANS IN 1920.** During 1920 there were 2,379 physicians whose deaths were reported in the United States and Canada. On an estimate of 160,000 physicians in the United States and Canada, this is equivalent to an annual death rate of about 14.81 per thousand. The average annual mortality rate for the period from 1902 to 1920, inclusive, was therefore, 15.46 per thousand. Of the 2272 decedents whose age was stated, 37 were under 30; 174 between 31 and 40; 351 between 41 and 50; 463 between 51 and 60; 541 between 61 and 70; 436 between 71 and 80; 208 between 81 and 90 and 19 between 91 and 100. The greatest number of deaths for a given age occurred at 63 and 64 years, at each of which ages sixty-five deaths are noted.

**AID TO RUSSIAN PHYSICIANS.** A number of Chicago physicians have formed an organization under Dr. George B. Hassin, Chairman, with office at 3155 Jackson Boulevard, for the medical relief of Russia and with the purpose of collecting and transmitting to the medical profession of that country the things most needed. An appeal is made to physicians, scientific societies and medical research laboratories to donate from their equipment whatever they can spare. Reduced to almost half their number by the war, it is said that the Russian physicians have to fight disease without drugs, medical supplies, instruments and other necessities.

**CREMATION OF HUMAN BODIES.** According to a report of the Cremation Society of England 1800 human bodies were cremated in Great Britain during 1920. Among the scientists of note whose bodies were cremated were those of Sir William Osler and Dr. Cecil Lyster.

**INTERNATIONAL SOCIETY OF UROLOGY.** The Congress of the International Society of Urology will be held in Paris, July 5-6, 1921. The three questions on the order of the day are: Nephritis with uremigenic syndrome; late results of treatment of traumatism of the ureter, and pyelography.

**THE NATIONAL RESEARCH COUNCIL** has established a Research Information Service as a general clearing house and information bureau for scientific and industrial research. This service, on request, supplies information concerning research problems, progress, laboratories, equipment, methods, publications, personnel, funds, and so forth. Ordinarily, inquiries are answered without charge, but when this is impossible because of unusual difficulty in securing information, the inquirer is notified and supplied with an estimate of cost. Requests for information should be addressed Research Information Service, National Research Council, 1701 Massachusetts Avenue, Washington, D. C.

**IMMUNIZATION AGAINST YELLOW FEVER.** Heretofore work in yellow fever control has been entirely that of prevention of infection, by controlling breeding places of the mosquito which carries the yellow fever germ. The isolation of the yellow fever germ has made it possible for Dr. Noguchi to develop a serum which it is believed will reduce the mortality from yellow fever and a vaccine

which gives promise of protecting the non-immunes against contracting the disease. In New York vaccination of people going to tropical countries is being made. Over a year ago the Rockefeller Institute sent three hundred bottles of the vaccine to Mexico; other shipments have been made since then, the latest on November 10. The Central American countries are so well convinced of the efficacy of Dr. Noguchi's vaccine that they are permitting travel without quarantine detention of those who have been successfully vaccinated.

REDUCTION IN NUMBER OF RED CROSS DIVISIONS IN THE UNITED STATES. The Central Committee of the Red Cross has decided that the number of divisions in the Red Cross shall be reduced from thirteen to seven.

THE AMERICAN INSTITUTE OF MEDICINE. This is an institution which was organized in 1919 and has for its purpose the effort to keep the busy physician in touch with the medical and surgical activities of the world. There is a Library Department, a research and Special Service Department, or a joint Department comprising both of these, and a Specialist Department. The Institution is glad to furnish information regarding its work, its staff, personnel and other matters of particular interest to prospective members. Information regarding the business integrity and standing of the Institute may be obtained from the usual commercial agencies, or from the Institute's banking connection in New York. Out of town physicians are cordially invited to visit the offices of the Institute when in New York City.

RE-ELECTED FOR SPECIAL JOURNALS OF THE A. M. A. At the meeting of the Board of Trustees of the American Medical Association held on February 5, the following fellows were re-elected for terms of six years to positions on the editorial boards of the special journals published by the association as indicated: Richard C. Cabot, Boston, *Archives of Internal Medicine*; John Howland, Baltimore, *American Journal of Diseases of Children*; Samuel T. Orten, Iowa City, *Archives of Neurology and Psychiatry*; Martin E. Engman, St. Louis, *Archives of Dermatology and Syphilology*. E. S. Judd, Rochester, Minnesota, was elected to the editorial board of the *Archives of Surgery*, succeeding Dr. William Mayo, who resigned.

**NEW PRESIDENT FOR YALE UNIVERSITY.** By unanimous vote the Yale Corporation elected James Rowland Angell as president of the university to succeed Arthur Twining Hadley at the close of the present university year. Dr. Angell is the son of the late President Angell of the University of Michigan. The election of Dr. Angell to the presidency of Yale comes as a result of ten months of study on the part of the Corporation to decide on the strongest man in America for the position. Some eighty names were under consideration for the position.

**MEETING OF AMERICAN DRUG MANUFACTURERS' ASSOCIATION.** The tenth annual meeting of the American Drug Manufacturers' Association will be held at the Hotel Biltmore, New York City, April 11-14. The convention will deal for the most part with the changes wrought by the present economic state of the country, the alcoholic medicinal problem and the problem of the sales tax.

**EIGHTY-EIGHTH ANNUAL MEETING OF THE TENNESSEE STATE MEDICAL ASSOCIATION.** This meeting will be held at Nashville on April 12-13 and 14, under the presidency of Dr. L. L. Sheddan, of Knoxville. There are few societies of any kind which have held eighty-seven annual meetings and the medical societies with as long a record of continuous service as that of the Tennessee State Medical Society are very few indeed.

**MADAME CURIE TO VISIT AMERICA.** Madame Marie Curie plans to come to America in May and will make quite an extended visit, according to an announcement by Dr. F. C. Wood, of the Crocker Memorial Cancer Research Laboratory, Chairman of the Committee which is to receive Madame Curie. Madame Curie, during her stay here will receive a gram of radium with which to experiment, the gift of a number of American women now engaged in raising the Madame Curie Radium Fund. Only women will be permitted to subscribe to this fund.

**CANCER IN NEW YORK.** The greatest number of deaths from cancer in one week in New York City is said to be 125, an average of about 18 a day. During 1920 there were 5361 deaths recorded in New York City from cancer, against 5026 in 1919, which is an increase of over 6.6 per cent. Against this the general yearly increase in cancer mortality in the whole United States has common-



ly been between 2 to 3 per cent. From July 1 to December 31, 2691 deaths from cancer were recorded, and only 2669 from tuberculosis, giving an excess of 22 cancer deaths.

**RAILWAY TRAVELERS TO HAVE CERTIFIED WATER.** The danger to railway travelers, so far as typhoid fever, dysentery and other water-borne diseases are concerned, has been considerably lessened through the efforts of the U. S. Public Health Service, working in co-operation with the state boards of health throughout the greater part of the country, in having the water tested which is used on trains for drinking and cooking. Within the next few months, it is expected that a similar protection will be afforded to passengers on river and lake steamers and to ocean steamships sailing from American ports.

**X-RAY FINGER PRINTS.** Dr. Henry Beclerc of Paris is reported to have proposed to the police service of that city a new and improved method of "fixing" finger-prints for permanent identification. The method calls for the rubbing into the lines and markings of the fingertips of a preparation of carbonate of bismuth or some other salt, which, when the fingers are photographed by means of the X-ray, shows corresponding opaque marks in the picture thus made. The *Medical Record*, in noting the above, observes further that an additional advantage consists in the fact that the radiographic picture shows also the skeleton of the fingers and the outlines and special form of the nail.

**DR. AMEDEE GRANGER WAS GRANTED A BASIC PATENT** by the U. S. Government for his new method of localizing foreign bodies in the human tissues by means of the X-rays. This patent not only covers the localizing instrument invented by the Doctor in 1917 but any device employing the same method. Early in 1918 the Granger Localizer was adopted by the Medical Department of the Navy. The Medical Department of the Army did not adopt the localizer but has been using the method. One of the localizers was sent to the Military Hospital of the Val-de-Grace in Paris where it is still in use. For this action and because of his other contributions to the science of Radiology the French Government has recently bestowed on Doctor Granger the decoration of the "Palmes Académiques" which carries with it the title of Officer of Academy.

**PERSONALS.** Drs. P. Graffagnino and W. O'D. Jones have been appointed house surgeons of the Charity Hospital. Drs. Sam Hobson and E. L. Irwin have been appointed from the internes house officers to serve on the medical staff. Drs. Graffagnino and Jones have succeeded Drs. J. E. Landry and M. J. Gelpi, resigned.

**REMOVALS.** Dr. C. M. Toler, from Elizabeth, La., to Ault, Colorado.

**DIED.** Dr. Otto Ehlinger, of New Orleans, on February 28, 1921.

Dr. Joseph Conn, of New Orleans, on March 4, 1921.

On March 21, Dr. Wm. A. Kohlmann, of this city, aged 58 years, a director of the Loyola medical school and professor of gynecology in Loyola post-graduate medical school. Dr. Kohlmann was one of the country's high authorities on gynecological surgery. He was a member of the American College of Surgeons, Chairman Medical Staff of Touro Infirmary and one of the chiefs of the gynecological service of Charity Hospital.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

**Refraction and Motility of The Eye**, by Ellice M. Alger, M. D., F. A. C. S. F. A. Davis Company, Philadelphia, Pa., 1920.

In this second edition of a most popular book the author has brought the subjects up to the present time. The book contains the originally prepared lectures that the writer has been giving to his post-graduate students; it is very nicely gotten up and is most pleasing to review, for it is well illustrated and is not a collection of laws governing refraction and motility of the eyes, but a practical book without sacrificing the essentials. It is to be recommended as a text-book for the post-graduate student as well as the undergraduate student. In brief, "it is a post-graduate course on refraction and motility of the eye," and is presented in a style which is easily comprehended.

T. J. DIMITRY.

**Heart Affections, Their Recognition and Treatment**, by S. Calvin Smith, M. S., M. D. Philadelphia. F. A. Davis Company, 1920.

The author has aimed to make a book that does not presuppose a knowledge of the subject and that strives to encompass in small volume sufficient fundamentals of anatomy, physiology, pathology, and treat-

ment to give the busy physician a working knowledge of the more recent advances in studies of the heart. That such knowledge is greatly needed by many of our profession is unquestioned and a careful perusal of this work indicates that the author has come close to realizing his aim. The chapters on examination of the patient, including those on the graphic methods, are especially to be commended. Many clinicians of experience will differ with Dr. Smith's views as to the value, method of action, and dosage of various so-called cardiac drugs. It hardly seems credible in the light of the clinical reports of Eggleston, Canby Robinson, and practically all modern clinical students of heart diseases, that an author should at this date write "even though as much as three drams (of the tincture of digitalis) in twenty-four hours be thus administered," as if that were an exceptionally large dose. The excellent typographical work is to be highly commended. J. T. H.

## PUBLICATIONS RECEIVED

**THE MACMILLAN COMPANY**, New York.

American Red Cross Work Among the French People, by Fisher Ames, Jr.

**C. V. MOSBY COMPANY**, St. Louis.

Practical Tuberculosis, by Herbert F. Gammons, M. D.

**F. A. DAVIS COMPANY**, Philadelphia.

Optimistic Medicine, by A Former Insurance Man.

**W. B. SAUNDERS COMPANY**, Philadelphia and London.

The Medical Clinics of North America, Vol. 4, No. 4, January, 1921.

**WASHINGTON GOVERNMENT PRINTING OFFICE**, Washington, D. C.

Annual Report of the Surgeon General of the Public Health Service, for the year 1920.

**U. S. Department of Agriculture Service and Regulatory Announcements. Supplement.** Notices of Judgment Under the Food and Drugs Act. February 9, 1921.

Public Health Reports, Volume 36, Nos. 5, 6, 7, 8.

Public Health Bulletin No. 108.

### MISCELLANEOUS:

Transactions of the American Pediatric Society, 1920.

Johns Hopkins Hospital Reports, Vol. 20, Fasciculus 1 and 2, Vol. 21, Fasciculus 2. The Johns Hopkins Press, Baltimore.

### REPRINTS.

The Epidemic of Pneumonia Following Influenza at Camp Logan, Texas, by Drs. J. N. Hall, M. C. Stone and John C. Simpson.

Appendicitis at Camp Logan as a Sequel to Influenza and Pneumonia, by Drs. J. N. Hall and Frederick G. Dyas.

Epigastric Hernia in the Soldier, by J. N. Hall, M. D.

Empyema: Clinical Diagnosis; X-ray Diagnosis, by J. N. Hall, M. D.

Sobre Encefalitis Letargica, by Dr. G. B. Cavazzutti.

Dispositifs D' Amelioration Des Membres Artificiels (1), by Dr. M. Gabriel Bidou.

Mis Treinta y Siete Dias De Ayuno (Auto-Experiencia), by Dr. Luis C. Maglioni.

**MORTUARY REPORT OF NEW ORLEANS.**

Computed from the Monthly Report of the Board of Health of the City of  
New Orleans, for February, 1921.

CAUSE.	White.	Colored.	Total.
Typhoid Fever			
Intermittent Fever (Malarial Cachexia)	2	1	3
Smallpox	1	8	9
Measles	14		14
Scarlet Fever			
Whooping Cough	1		1
Diphtheria and Croup	1		1
Influenza	3	3	6
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	33	28	61
Cancer	19	6	25
Rheumatism and Gout	1	1	2
Diabetes	5		5
Alcoholism			
Encephalitis and Meningitis	2	1	3
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	22	6	28
Paralysis	2	2	4
Convulsions of Infancy		1	1
Other Diseases of Infancy	7	10	17
Tetanus			
Other Nervous Diseases	3	1	4
Heart Diseases	73	37	110
Bronchitis	1	2	3
Pneumonia and Broncho-Pneumonia	36	31	67
Other Respiratory Diseases	3		3
Ulcer of Stomach			
Other Diseases of the Stomach	2	1	3
Diarrhea, Dysentery and Enteritis	7	10	17
Hernia, Intestinal Obstruction	2	1	3
Cirrhosis of Liver		3	3
Other Diseases of the Liver	1	1	2
Simple Peritonitis			
Appendicitis	5	1	6
Bright's Disease	26	8	34
Other Genito-Urinary Diseases	13	12	25
Puerperal Diseases	6	3	9
Senile Debility			
Suicide	7	1	8
Injuries	21	6	27
All Other Causes	20	29	49
<b>TOTAL</b>	<b>339</b>	<b>214</b>	<b>553</b>

Still-born Children—White, 19; colored, 15; total, 34.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death rate per 1000 per annum for Month—White, 14.03; colored, 23.35; total, 16.59. Non-residents excluded, 14.55.

**METEOROLOGIC SUMMARY (U. S. Weather Bureau).**

Mean atmospheric pressure..... 30.10  
 Mean temperature . . . . . 60.  
 Total precipitation . . . . . 1.94 inches  
 Prevailing direction of wind, southwest.



# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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EDITOR: CHAS. CHASSAIGNAC, M. D.

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## EDITORIAL

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### TYPHOID FEVER IN NEW ORLEANS.

A survey of the mortality from typhoid fever in the large cities of the union during 1920, published in a recent number of the *Journal of the A. M. A.*, furnishes very interesting facts from which practical deductions easily may be drawn.

New Orleans makes a favorable showing, with 7.4 deaths per 100,000 of population per annum, in so far as it is a decline from 13.7 for the previous year and from 35.6, its average for the five years 1906 to 1910. On the other hand, a further study of the survey shows that New Orleans is the fifty-third in standing of the sixty-eight cities of more than 100,000 population, those listed by the *Journal*, which means that our standing is well below the middle. Our civic and our professional pride both should stimulate us individually as well as officially to renewed effort towards the betterment of our typhoid record.

When we see further that six of the cities listed are credited

with less than two deaths per 100,000 of population for the year 1920, we receive a clear impression of the room for improvement which exists.

Of the diseases considered preventable, typhoid is one of the best understood. Secure pure water and unpolluted milk, stop the breeding of flies or destroy them, locate and eliminate carriers—and the typhoid problem is solved. This does not mean that typhoid fever would be eradicated from a city, as there still would be cases and fatalities among the non-residents and from suburban sources of contamination, but the total mortality from these sources would be small and would gradually decrease as sanitary measures became more generally and more efficiently applied.

Obviously all these things are more easily said than done. To attain them will be required hard work, intelligent effort and monetary outlay on the part of civic and sanitary officials. The individual physician can do his part by carefully diagnosing and promptly reporting his cases, in order that their source may be traced. He can help to educate the citizens up to the point of recognizing the importance of the necessary preventive measures and he can co-operate with the health authorities in their efforts to carry out collective prophylaxis.

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### **CHARITY HOSPITAL PROGRESS.**

Very noticeable progress in the affairs of the Charity Hospital is seen from every angle and it is with pleasure that we make comment upon the advance. We do not place the credit for this change to any individual but we give praise to the many who have been for years laboring to accomplish this growth. Many have worked to obtain this result. It appears that the disgruntled provoked this constructive work, but it is with difficulty that we could cite a few who were satisfied with conditions existing in the hospital.

The commendation for this progress belongs to the Board, the good Sisters, the Superintendent and especially the Staff, who have been organized, and have suggested, assisted and carried their share of the advance. The most noticeable accomplishment is that of the meetings of the Staff. These are harmonious, deliberate and free from factional feelings.

Again it is noticeable that the Board is not holding itself aloof but is lending encouragement to these efforts, realizing the great

benefit which must accrue to the institution. We cherish the hope, and we see no reason why this wish should not be realized, that this spirit of harmony will prevail and that the old Charity will continue one of the country's foremost hospitals. The JOURNAL will not sit idly by but will lend assistance to this movement forward and its pages will be ever open to assist the cause.

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### THE AMERICAN JOURNAL OF TROPICAL MEDICINE.

The first number of the above named Journal, for January, 1921, has just been issued. It is to be published bimonthly as the official organ of the American Society of Tropical Medicine. We welcome its entry into the ranks and are interested in its career not only because of our general concern in medical journalism but on account of the special attention we have given the subject of tropical medicine in this publication and in the *American Journal of Tropical Diseases* which was for several years the official organ of the Society of Tropical Medicine and became incorporated in this JOURNAL when the separate existence of the *Tropical Journal* became financially impossible.

The initial number contains the reports of the officers of the Tropical Society for 1919-1920 and several very interesting articles, two of which have already been published—one in the *Journal of the A. M. A.*, to which credit is given for same, and one in this JOURNAL, for which acknowledgment is not made, no doubt by oversight.

The new journal is published by the Williams and Wilkins Company, of Baltimore, and appears in large clear type on good paper, making a very favorable first impression.

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### MEDICAL CORPS OF THE NAVY.

The Surgeon General of the United States Navy informs us that there exist at present a large number of vacancies in its Medical Corps and that examinations will be held at frequent intervals in several of the coast cities of this country, the nearest to this point being at Charleston, S. C. and North Chicago, Illinois.

For the time being appointments will be made directly into the Medical Corps instead of by preliminary enrollment in the Naval Reserve Force as heretofore.

The physical requirements will remain the same but the professional examination will be on general surgery, general medicine, general hygiene and sanitation; also a practical examination will be included.

Service in the Navy should be attractive to young men as the opportunities for study and research as well as for travel are large, and the pay, to which additions have recently been authorized, is not unattractive.

Prospective candidates should write to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., for further information.

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### STATE SOCIETY MEETING.

As this number is being printed the forty-second annual meeting of the Louisiana State Medical Society is going on. It is possible, however, to judge that it will prove an unqualified success. The program is being carried out on time, the quality of the papers so far are up to the standard, while the entertainments have seemed to furnish enjoyment to our visitors. The chief feature, the stag frolic of the first night, included a well prepared dinner, a musical number and a vaudeville entertainment which was found amusing without shocking any one's sense of proprieties.

The following is the list of the principal officers nominated for next year: President, J. E. Knighton, of Shreveport; first vice-president, Wm. H. Harris, of New Orleans; second vice-president, Bruce Wallace, Alexandria; third vice-president, T. A. Roy, Mansura. The secretary-treasurer holds over and the society will continue to profit by his efficient service during the coming year.

Alexandria was chosen as the meeting place for 1922.

The retiring officers and the committee of arrangements are to be warmly commended for their efforts and the success with which they were crowned.



## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### THE SPECIFIC AND NON-SPECIFIC IMMUNITIES,

By G. H. SHERMAN, M. D., Detroit, Mich.

Practical immunology has demonstrated that immunizing responses resulting from vaccine injections assume both a specific and nonspecific character. The specific immunizing action of vaccines has received by far the greater amount of attention because it appealed most forcibly to the general concepts of immunity to the various infecting organisms. And, reasoning from this premise it naturally followed that autogenous vaccines, being prepared from the identical organisms that are responsible for the infections were regarded as serving the best purpose. This concept of the absolute specific action of vaccines became so thoroughly fixed that autogenous vaccines were thought to be the only ones that should be employed and if a patient made no satisfactory improvement under autogenous vaccines, vaccine treatment was abandoned as not being available in that case.

That this specific immunizing action of vaccines is not the only method employed in developing immunizing responses was gradually ascertained by clinical experience. In this regard Wright (*The Lancet*, March 29, 1919) says:

"I confess to having shared the conviction that immunization is always strictly specific. Twenty years ago, when it was alleged, before the Indian Plague Commission, that antiplague inoculation had cured eczema, gonorrhoea, and other miscellaneous infection, I thought the matter undeserving of examination. I took the same view when it was reported in connection with antityphoid inoculation that it rendered the patients much less susceptible to malaria. Again, seven years ago, when applying pneumococcus inoculations as a preventive against pneumonia in the Transvaal mines, I nourished exactly the same prejudices. But here the statistical results which were obtained in the Premier Mine demonstrated that the pneumococcus inoculations had, in addition to bringing down the mortality from pneumonia by 85 per cent, reduced also the mor-

tality from "other diseases" by 50 per cent. From that on we had to take up into our categories the fact that inoculation produces in addition to "direct" also "collateral" immunization. This once recognized, presumptive evidence of collateral immunization began gradually to filter into our minds. Among, I suppose, many thousands of patients treated by vaccine therapy in private and in hospital, it happened every now and then that a patient was treated with a vaccine which did not correspond with his infection, and that that patient indubitably benefited. Again, it was not an uncommon experience for the subjects of a very chronic infection (such as pyorrhoea) who were treated first by a stock vaccine, and afterwards with an auto-vaccine, to assert that they derived more benefit from, and to ask to be put back upon treatment by, the stock vaccine.

"From such cases hints are conveyed to us that there may exist a useful sphere of application for collateral immunization; and that such sphere may, perhaps be found in those cases where the infection is of very long standing, and where the patient has become very sensitive to, and has probably come very near the end of his tether in the matter of immunizing response to the particular species or strain of microbe with which he is infected. It will, with regard to such patients, be remembered that they constitute the third of those three classes of cases to which I referred at the outset of this lecture as very intractable to vaccine therapy.

"We are, however, here considering primarily the question of principle; and in connection with this what is of fundamental importance is: that we should discard the confident dogmatic belief that immunization must be strictly specific, and that we should in every case of failure endeavor to make our immunization more and more strictly specific. We should instead proceed upon the principle that the best vaccine to employ will always be the vaccine which gives on trial the best immunizing response against the microbe we propose to combat."

A careful analysis of prevailing conditions after recovery from infectious diseases would indicate that this nonspecific collateral immunity is a prevailing factor in the process of specific immunization. We find that persons who have recovered and by recovered we mean that they have been completely restored to health from typhoid fever, measles, scarlet fever or other acute infections, are not as susceptible to infections for some considerable length of

time as the average individual. As a rule they enjoy exceptional good health and frequently the resistance to infection that has developed can best be explained by nonspecific immunizing responses. And this is an important natural provision. If this were not the case infections would be liable to follow one after another to an enormous disadvantage to those recovering from infectious diseases.

Prophylactic and therapeutic immunization by means of bacterial vaccines includes all the immunizing principles that obtain in acquired immunization during the course of an infection in an intensified form. And to obtain the best results the vaccine must contain organisms which will take due advantage of both the specific and nonspecific properties of the immunizing function. These properties of a bacterial vaccine can only be determined by extensive clinical observation over a long period of time and the results of such observations have led to a general conviction among extensive vaccine users that polyvalent mixed vaccines serve the best purpose. By this means the immunizing faculty is aroused from various angles and by repeating the inoculations these multiple immunizing influences are prolonged over a long period of time. This is where forced immunization by means of vaccine inoculations offers a distinct advantage over immunities that are produced by overcoming an infection without the aid of vaccines. Often the immunity following an infection is just enough to overcome infection; leaving the patient in a condition where the slight immunity that has been established will soon wear off when the relapse of the same infection is liable to follow. By continuing vaccine inoculations after apparent immunity has been established the immunity becomes intensified and more lasting. This is well illustrated in cases of erysipelas. It is well known an attack of erysipelas predisposes the individual to future attacks. If, however, vaccines are employed in the treatment of erysipelas and several more doses given after the infection has subsided the erysipelas seldom recurs. Pneumonia is another disease in which an attack makes the subject more susceptible to contracting the disease again. This tendency is avoided by treating pneumonia cases with vaccines and continuing the inoculations until recovery is complete.

The thought has been advanced that after immunizing responses have become well established from the use of vaccines during an infection the antigenic influence of the infecting organisms will

prolong the immunizing activity until the infection is overcome. Clinical experience shows that this is not true. In many instances it is found when an infection is brought well under control after giving a few doses of vaccine and if the vaccine treatment is then discontinued the infection will flare up and again be brought under control after further vaccine injections. This would certainly show that the antigenic influences of the live organisms which are responsible for the infection are not as dependable and effective as the antigenic properties possessed by the killed organisms in the injected vaccine. This is not sufficiently appreciated by those who have not had extensive experience with the use of vaccines. If after favorable progress from a few doses of vaccine the patient gets worse again, too often further vaccine treatment is not resorted to because of insufficient confidence in the efficiency of vaccines, whereas the fault is not with the vaccine at all, but with an inadequate use of it. Vaccines, like other therapeutic agents, are only useful when properly applied and when applied so both the specific and nonspecific immunizing influences are taken advantage of most satisfactory results are obtained.

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### THE PATULOUS APPENDIX—A TOXIC FOCUS.\*

By DR. W. A. LOVE.

The caption under which this paper is presented may appear to you to be somewhat ambiguous. As a title it would, perhaps, have been better to have selected one in the form of the interrogation: *When is the patulous appendix a toxic focus?* This heading would have served better for we are given to understand, by the anatomists, that the normal appendix is patulous and it is not my intent to deal with what may be considered as a normal appendix. To explain the terms of the caption as I shall employ them, I wish to state that I consider a *focus* as a source of infection and that I employ the term *toxic* in contradistinction to *septic* or pus-forming. Therefore, we are to discuss a concept of the patulous appendix under the conditions which make it a toxic and non-pyogenic source of systemic infection.

Infections within the human body are blood-borne poisonings and are typically divided into three great classes, viz: those due to pyogenic or septic toxins; those due to toxins of infectious

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\* Read before the Orleans Parish Medical Society, March 14, 1921.



diseases, and those due to reabsorption into the systemic circulation of the end products of decomposition or putrefaction of endogenous or exogenous material. It is with poisonings of the last class, exogenous in origin and due to putrefaction and decomposition of ingested matter, that we will deal in our discussion of the effect upon the human organism of toxins arising through the pathological presence of a certain type of the abnormal, patulous appendix.

The appendix is described as a small tube of doubtful physiological function arising from and emptying into the cecum and terminating as a blind pouch of varying degree of length. Anatomically it is fairly identical with the general structure of the large gut, possesses the same number of coats, the same peritoneal covering and mucous membrane lining and the same general glandular arrangement submucously. The radio-physiologists tell us that peristalsis takes place in the normal appendix and that the peristaltic waves are exerted from tip to lumen in minute bead-like waves and that the appendiceal contents are expressed into the cecum thereby. As part of this appendiceal content is also expressed into the cecum the appendiceal secretion which has some undiscovered function in the cecal digestive process. Therefore, we logically deduce that the organ was ordained to be patulous and to follow its normal function of emptying its contents into the cecum during the cecal stage of bowel digestion. We must consider, therefore, that during the cecal stage of digestion the appendix fills and empties with the filling and emptying of the cecum. The appendix, being a blind pouch, is probably filled by the force of the antiperistaltic waves of the cecum as they exert back pressure toward the head of the cecum and the ileo-cecal valve and that it empties due to the action of the peristaltic waves within the appendix which travel as before stated from the tip toward the lumen. Consequently, under conditions of health the contents of the cecum and of the appendix may be considered as practically one and the same material and we logically assume that, as the cecum empties, the appendix empties coincidentally and simultaneously. It is during this stage of the digestion and elimination process that absorption of nutrient matter is completed and the cecal contents become a part of the putrefying mass of fecal matter that eventually occupies the last half of the transverse colon, the descending colon and the sigmoid-rectal area.

Inflammation produces certain physiological changes in the action of the appendix. This inflammation is not due to infection arising within the lumen of the appendix, except in the case of the lodgment therein of foreign bodies with consequent laceration of the mucosa, but to exudative changes in the walls. Stengel states that when an appendicitis subsides and the lumen of the organ is restored, interstitial changes take place within the walls in direct proportion to the severity of the inflammation. Hence, we have after each attack of appendiceal inflammation some thickening of the walls of the organ. In direct ratio to this thickening or interstitial hyperplasia, we have a modification or lessening of the physiological function of peristalsis in the appendix with delayed emptying and stasis produced. An attack of appendicitis, however mild, is accepted axiomatically as predisposing to subsequent attacks each of which tends to increase the interstitial hypertrophy of the organ until it assumes a true state of chronic interstitial appendicitis. The same pathology that is produced, as is manifest in the other abdominal organs which are subjected to prolonged or frequent inflammations, is shown in the appendix which is subjected to recurrent attacks of mild inflammation and just as we have interstitial thickening of the liver and kidney with subsequent shrinking, we have the chronic interstitial appendicitis produced with consequent loss of peristaltic motility. Occasionally we have lumen obliteration incidental to the interstitial change, but in discussing the patulous appendix we are not concerned with this type. Moreover, as we are not discussing the etiology of appendicitis, I will not attempt to decide as to whether the infection causing acute attacks of appendiceal inflammation is blood-borne to the organ or the result of extended infection from the cecum. To summarize the pathology of the organ under conditions which make it a possible toxic focus we find it in a state of chronic interstitial appendicitis, patulous but devoid of sufficient peristaltic power to empty its lumen coincidentally and simultaneously with the emptying of the cecum. The patulous appendix in which stasis exists is, therefore, one into which the cecal contents find ready entrance but tardy exit. Radiographically checked, this tardiness may be of duration from a few hours to indefinite periods. I will ask Dr. Henriques to elaborate upon this point in the discussion as he has made some interesting observations in this regard.

The logical query now follows as to what conditions arise bacteri-

ologically and chemically in the retained material present in the appendix under the described conditions of stasis after the cecum has emptied. In the normal schedule of elimination from the large intestine, the waste material from the ingesta and the unabsorbed end products of digestion are eliminated from the body before putrefaction and decomposition have been sufficiently exerted upon these substances to produce any deleterious quantity of putrefactive toxin for absorption into the inferior mesenteric circulation. Stasis in the large bowel results in reabsorption of excessive amounts of putrefactive toxins in direct ratio to the duration of stasis and the quantity of putrefactive bacteria and enzymes present in the colon. I will not dwell at length upon the variety of colonic flora and enzymes, as this can be obtained from any standard text, but will state that there is no occasion to believe that stasis in the appendix will cause any departure from the usual ratio of decomposition and putrefaction which applies to stasis in other parts of the large gut. Hence, if we consider stasis in the patulous appendix we must visualize a state of affairs in which a portion of the content of the large bowel is delayed and exposed to the action of the putrefactive bacteria and enzymes of the colon at most favorable incubating conditions of moisture, culture media and body temperature. Studies of the bacterial content of the chronic appendix show that, according to Deaver, the colon bacillus predominated in 89% of cases examined by him and Rosenow cites better than 80% colon bacillus as his experience. These statistics include the obliterative types and I am inclined to believe that the colon bacillus and attending putrefactive bacteria and enzymes can be demonstrated in all patulous cases but unfortunately I cannot confirm this belief with statistics from the literature.

The patulous, stagnant appendix is in effect a culture tube presenting itself under incubation and with open mouth for the deliverance of its virulent strains of bacteria at the very first portion of the eliminating sewer of the body to pollute the sewer contents as they arrive from the small intestine via the ileo-cecal valve. At the time that the small intestine empties, active stomach-like peristalsis is set up in the cecum which favors the admixture with the cecal contents of the bacteria elaborated within the stagnant appendix.

How does our patulous, stagnant, chronic interstitial appendix act as a focus of infection? In two ways; the first a possibility

and the second, to my mind, an actuality. Admitting that we are dealing with a pouch in which stasis exists and in which putrefactive toxins are being elaborated, we will realize that there are two routes by which these toxins may reach the portal circulation; 1. Absorption direct via the venous capillaries of the appendix and 2. Secondary absorption via the venous capillaries submucously situated in the cecum and colon. I am disinclined to believe that absorption via the appendiceal capillaries is very great because the material is not under pressure and the interstitial change producing the character of appendix under consideration is a direct protection against the likelihood of such direct absorption. Clinical observations have forced me to realize the importance of the secondary absorption via the large bowel and the role played by the stagnant appendix as a reinfecting agent in cases of persistent excessive intestinal toxemia of the putrefactive type.

It might be well at this time to interpolate a concept of the etiology of chronic excessive intestinal toxemia of the putrefactive type which I trust will be acceptable to my hearers. To my way of thinking, nature has established a schedule of elimination which eliminates likelihood of excess of toxic absorption from the colon as before detailed. If this schedule is upset and there is a delay in elimination or if excessive quantities of putrefactive bacteria are produced in the large bowel or its appendages the result will be an excess of toxic reabsorption into the portal circulation of these toxins produced by the action upon the undigested albuminoid residue and the unabsorbed amino acid end products of proteid digestion of the colon bacillus and its allied putrefactive bacteria and enzymes. Until these residue substances are acted upon by putrefactive bacteria, they are of themselves non-toxic but the putrefactive amines produced by decomposition are real tissue poisons. Upon being reabsorbed, these toxic amines are carried to the liver via the portal circulation and it is the function of the liver to neutralize them but this function of the liver is limited and any great excess over normal results in a portion finding egress into the general circulation where they act as toxic systemic poisons. These poisons are basic in character and have a pathological effect upon all tissues with which they come in contact causing manifestations of irritation and eventually causing reactionary interstitial changes in the tissues. These interstitial changes are particularly manifest in the organs called upon to carry and eliminate



the poisons, viz: the blood vessels, heart, kidneys and liver. Numbers of the toxic amines have selective actions in producing special systemic symptoms as has been clearly proven by Barger and Dale in experimental injection of isolated toxic amines for the production of urticaria, spasmodic asthma, elevations and reductions of blood pressure, etc.

My attention was first called to the possibilities of the patulous appendix in a condition of stasis as a reinfesting agency in chronic intestinal toxemia by my inability to clear up certain cases of this character by the routine measures which proved successful in other cases. These cases were of the putrefactive type as evidenced by excessive indicanuria and not of the fermentative type. Just at the time when I was congratulating myself that I had produced a desirable condition in the colon and that the normal schedule between putrefaction and elimination had been reestablished I found that the admission of the smallest amounts of albuminoid proteid food into the diet was productive of a return of the symptoms and an excess production of indican in the urine. In some cases I found that I could not produce a healthy colonic state at all.

X-ray examination of a number of the above classes of cases brought to me forcibly the coincidence between the occurrence of the patulous appendix with stasis and my inability to clear up the intestinal toxemia satisfactorily.

The signs and symptoms of the patulous appendix as a toxic focus are therefore, I believe, those of intestinal toxemia which does not yield to routine and accepted measures usually employed in treatment and it is as logical to eliminate this possible focus in making our routine examination in search of hidden foci of infection as it is to examine the tooth sockets, sinuses, antrums, prostate, etc. It is generally understood and accepted at this time that intestinal toxemia may produce such symptoms as fatigue, anorexia, urticaria, spasmodic asthma, migraine headache, neuralgia, peripheral neuritis, myocarditis, peri-articular inflammations, etc., and when we find that the intestinal toxemia does not yield to the accepted lines of treatment we owe it to our patient to complete the gastro-intestinal examination by X-ray examination and bearing in mind, as these X-rays are made, the possibility of the patulous appendix as a toxic focus.

The following are a few of the cases of type described that I have had under observation:

Case 1. C. H. A., white, male, age 42 years. Applied complaining of severe fatigue and shortness of breath on exertion. Routine physical examination negative with exception of Systolic B. P. of 98. No heart murmurs or appreciable loss of weight. Some edema of ankles. Urine examination negative with exception of high S. G. and heavy indican reaction. Diagnosis made of myocarditis without valvular insufficiency.

Careful search failed to reveal any foci of infection except the large intestine. Routine treatment for intestinal toxemia was carried out during 6 weeks of rest treatment for heart condition. Test meal of tomato peelings passed by subject 8 days after ingestion. Routine gastro-intestinal X-ray examination showed cecal stasis, appendiceal stasis. Bismuth remained in appendix 9 days after meal was given. It may have remained longer but no examination made after 9 days. In meantime subject had received enema every 48 hours and 2 purges with salines. Subject refused operation and continued in poor health. Went north for health and was operated upon one year later. Toxemia cleared up and has regained normal health since removal of appendix.

Case 2. G. A. H., white male, age 24, applied, complaining of loss of 20 pounds in weight and inability to sleep on account of severe pains in muscles of lower extremities. Wassermann blood cultures negative. No leucocytosis. Urine showed excessive persistent indicanuria under most careful treatment. Examination of all possible foci of infection failed to show any except large intestine. Case remained under treatment for intestinal toxemia for 2 months and became worse rather than improving. Diagnosis made of peripheral neuritis diffuse over lower limbs and lumbar area of back. Patient finally resorted to crutches.

Dr. Henriques made routine X-ray of gastro-intestinal tract at this time and reported 48-hour appendiceal stasis. Suggested operation to patient in hope of relieving toxemia. Dr. Phillips removed appendix and can bear me out that 10 days later patient walked without his crutches and was entirely free from pain. He gained 35 pounds in the subsequent 2 months.

Cases 3 and 4. K. B. and I. K., both white females of 20 to 25 years and for sake of brevity I will describe together as they were clinically fairly identical.

Both applied complaining of diffuse muscle pains, loss of appetite and hyperacidity of over 1 year of duration. Both had lost about 25 pounds and complained of insomnia. Normal menstrual history and both were unmarried. Heart and lungs in both cases were normal as was blood examination for malaria, syphilis, and leucocytosis. Blood in both cases showed a low neutrophile count and high mono-nuclear leucocyte content. Urine in both cases showed an indicanuria that persisted after 4 to 5 months of routine treatment. Dr. Henriques reported 48 to 72 hours of appendiceal stasis. Removal of the appendix relieved the intestinal toxemia and cases rapidly regained normal weight with entire cessation of symptoms.

Case 5. F. C., white male, age 24. Applied for relief of spasmodic attacks of asthma 4 years ago and has been under observation since. All possible foci of infection eliminated and all possible reflex disturbances studied with conclusion that attacks are caused by exacerbations of chronic intestinal toxemia upon the least indulgence in high proteid diet. While diet is watched, subject is a border-line case, asth-

matic but free from paroxysms except when he overindulges in proteid albuminoids. X-ray shows patulous appendix with over 24 hour stasis. After 4 years of study with this case, I am satisfied that if the appendix is removed we can relieve the intestinal toxemia and the consequent toxic asthma.

These cases are instanced as types and in presenting them I am not trying to "Ride a Hobby" but to state that, from an experience of several years in observing intestinal toxemias, I am of the opinion that they were relieved or are relievable by the removal of a patulous stagnant appendix which acted as a reinfecting agency and stood in the way of proper treatment of the existing and persistent chronic excessive intestinal putrefaction.

#### DISCUSSION.

**Dr. A. Jacoby:** It was a surprise to me to know that a patulous appendix was the cause of any infection. My impression has been that only those appendices which are blocked either by cicatrix or by fecal stone will cause any disturbance. The appendix is blamed for many diseases and its removal seems to have proven a cure in the hands of many surgeons. Personally, I am very skeptical of these cures and I do not think that its removal is a "cure-all" for the many diseases that it is supposed to be accountable for.

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#### CASE REPORT.\*

By DR. F. W. PARHAM.

The case I bring before you tonight is one of peculiar interest for several reasons.

He entered my service in December, 1920, presenting the signs of a profound anemia. The blood examination afforded a strong suspicion of pernicious anemia. I asked Dr. Weis to see the case on this account. We went into the history very carefully eliciting the following facts:

For the past year he has been having occasional hemorrhages from the bowel some of them quite profuse. The last about a week ago was quite copious, but there has been none since. The origin of these hemorrhages we have not been able definitely to make out, but a history of indigestion and the complaint of pain some time after eating and the absence of blood by vomit has made us strongly suspect an ulcer of the duodenum.

The indications for treatment were two: 1. To guard against further bleeding. 2. To build up the blood.

These indications were met on January 10 by a transfusion of

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\*Read before the Orleans Parish Medical Society, February 28, 1921.

350 cc of blood from a donor in the same group 4, as determined by tests by the pathological department of the hospital. 500 cc were drawn from the donor, but not all was given because of a severe anaphylaxis which came on after somewhat over 300 cc had been given. This steadily became more pronounced so that we discontinued after about 350 cc were in. The administration of ether by inhalation gradually overcame the anaphylaxis and he was sent back to bed much improved. With strict rest in bed and the administration of arsenic and Blaud's pills he has steadily improved as you can observe. His blood count substantiates this observation. The reds gradually increased in number until today (the day of this meeting) they have reached over 4,000,000. The hemoglobin which at first was 35 is today 70%. There has been no more bleeding. There are other interesting features but the time allotted forbids.

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### **CASE REPORT.\***

By DR. W. T. PATTON.

I am presenting this case for two reasons, first because it is a very interesting condition, second because it illustrates what awful conditions neglect of discharging ears may cause.

This little girl, now four years old, was brought to the hospital sixteen months ago, suffering from double discharging ears and double acute mastoiditis. The father refused to leave the child in the hospital.

The child was again brought to the hospital about two months ago, with sinus entering both mastoids, both ears discharging. History of case said both mastoids had been incised after child left hospital and never healed. A double simple mastoid was performed about six weeks ago; mastoids were found to be badly diseased. It was thought best not to do a radical operation at this time.

The child did very well but wound would not close. It was noticed at this time that child only talked in a peculiar jabber of its own. On testing it was found that she was totally deaf and both labyrinths were dead to coloric test. A radical mastoid was performed upon right side two weeks ago and now well. A radical will be done on left side in few days.

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\*Read before the Orleans Parish Medical Society, February 28, 1921.



The only thing we can do now, will be to put child in charge of a good teacher for lip reading, for she will be totally deaf for life.

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## REPORT OF TWO CASES OF LEPROSY.

By J. M. PERRET, M. D.

(From the Dr. J. T. Nix Clinic, New Orleans.)

Leprosy has been recognized in Louisiana since 1778. The disease is known to be endemic in our state. Osler says that Dyer in 1898 estimated the number of lepers in Louisiana as being between 300 and 500. There are probably more cases at the present time.

One afternoon in 1917, I visited a dermatological clinic in New Orleans and saw three cases of leprosy. Both cases to be reported were Louisianians; neither one had left the United States, indeed one had never been outside of Louisiana.

Many cases are undoubtedly going about at the present time without being diagnosed. Symptoms had lasted for five years in one of the cases, and for seven years in the other case, before they came to the clinic. Both had repeatedly sought medical advice and had come under the care of skilled observers, and for some reason that I fail to understand, their condition had escaped recognition.

It is interesting to speculate on how many cases these patients have infected during the long years that their disease was unrecognized. Their first complaint was a "cold in the head" and as we easily found the bacillus lepræ in their nasal secretions, we can well imagine what a danger they have been to the rest of the community.

The Wassermann reaction is strongly positive in leprosy. This is not as yet common knowledge and this seems to have been a stumbling block in the diagnosis of their cases. The positive Wassermann reaction was interpreted as meaning syphilis and the patient had been informed that they had "bad blood." A brief history of the cases follow:

Case No. 1. E. D., a white male, 23 years, a native of Louisiana, was seen at the clinic on March 24, 1920. He complained of the condition of his skin. For the past five years he has suffered from persistent head colds; his nose is always stopped up. One year ago he noticed that the sensation of his hands was getting bad and that he would frequently drop objects. At about the same time that the skin sensation of his hands was becoming affected, small lumps gradually

came out on his face. Three weeks ago a painless sore appeared on his left arm. His appetite is poor. Digestion good. Bowels are regular.

Past history. The patient has never travelled outside of the United States. When a boy he worked on a farm, later in an oil refinery up to three years ago, at which time he had to abandon his work on account of his present illness. For the past three years he has been helping his parents in their grocery store. The patient had always enjoyed good health up to his present illness.

Family history. Father and mother are living and well. They are of French descent. There are no known cases of tuberculosis, cancer or skin diseases in the family.

Physical examination. The face has numerous small anesthetic nodules and has the leonine expression. The lobules of the ears are enlarged. The nose is stopped up and admits but little air, on account of a rhinitis. There are small white nodules on the soft palate. The tongue is negative. There is advanced pyorrhoea alveolaris. The eyes are negative. The pupils are equal and react to light and accommodation. The knee jerks are negative.

Chest. Heart is negative. The lungs give evidence of infiltration. Abdominal examination is negative.

Extremities. The skin of the palms of the hands is glossy. On both forearms are numerous small anesthetic nodules. On the left arm is a small painless ulcer. The skin of the plantar surface of the left foot is scaly.

Laboratory examination. Urine is negative for albumin, sugar and indican. Total leucocytic count 6500 per c. m. Differential count: Small lymphocytes 25; Large lymphocytes 5; Neutrophils 70. Wassermann reaction: 4 +.

Smears made from the nasal secretion showed the presence of the bacilli of leprosy.

Case No. 2. J. H., white male, 21 years, a native of Louisiana, was seen at the clinic on January 4, 1921. He complained of his skin condition. Seven years ago he began to suffer from persistent head colds. Six years ago he underwent a nasal operation but was not relieved. Seven years ago he struck his right foot and developed an ulcer which has not healed to date. Three years ago it was noticed that his skin was getting rough. His appetite and digestion are good and his bowels are regular.

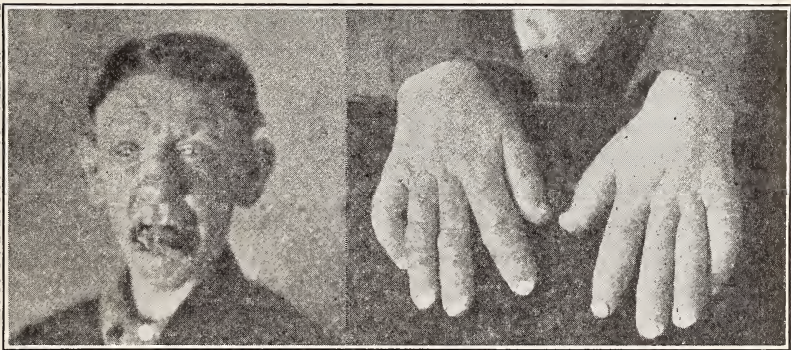
Past history. The patient has never left Louisiana. As the disease dates back to his boyhood the patient has never had any occupation. During childhood he suffered from earache. Eight years ago he sprained his right ankle.

Family history. Father and mother are both living and well. As far as is known, there have been no cases of cancer, tuberculosis or leprosy in the family.

Physical examination. This revealed a truly horrible picture equaled perhaps only by a severe case of smallpox. The face was leonine. It was covered with nodules. The lower lip had been ulcerated away so that there was constant dribbling of saliva. The patient covered his mouth with his handkerchief to hide his awful deformity. There were numerous ulcers in the buccal mucous membrane. There was pyorrhoea alveolaris. Tongue negative.

The patient's voice was very hoarse and he could hardly be understood when he spoke. The ears were enlarged to almost twice their normal size. The nose was swollen and ulcerations were present on its mucous membrane and there was a good deal of secretion, causing an almost constant snuffle. The fingers were deformed and swollen. The patient cannot hold anything in his hands and he is not able to dress himself. He wears large gloves to hide his hands. His toes are also swollen and there are several small trophic ulcers under toes of right foot. He has to wear tennis shoes. The skin of the elbows is thickened. There are large salmon colored nodules scattered over the trunk. Some of the lesions are anesthetic but not all.

Laboratory examinations. Wassermann reaction 4 +. Smears made from the nasal secretions showed the bacilli of leprosy.



The accompanying photographs show the face and hands of case No. 2. Both cases were reported to the health authorities by Dr. Nix. The diagnosis was confirmed and they were sent to the Leper's Home at Carville, La.

The laboratory work and the photography were done by Dr. E. Escalante.

#### SUMMARY.

1. Leprosy is endemic in Louisiana.
2. These two cases were native Louisianians, who had never left the United States. One had never been outside of Louisiana.
3. If a patient has a strongly positive Wassermann reaction and has some lesions which look syphilitic and yet do not clear up with anti-syphilitic treatment, let us not overlook the possibility of leprosy being the cause of the trouble.



## MERCUROSAL.

By JOHN L. MARCHAND, M. D., New Orleans, La.

With the, not original, statement that the question of the efficacy of our modern methods of combating the luetic infection is dependent largely upon the post-mortem findings of the next century of a certain percentage of "cures" among those subjects who had been treated by these methods, and not upon any test, serological or otherwise, now being employed for the purposes of diagnosis and treatment control, and that this important lack of evidence must qualify to a greater or lesser extent any report of the results of the recent exhibition especially of our modern remedial agents, I offer the following preliminary report of my experience with *Mercurosal*.

I have so far employed this remedy in the treatment of three cases of secondary lues, and of a case of very doubtful tertiary lues complicated (?) with Bright's Disease, not my own case, in all three instances in conjunction with arsphenamin, and in the treatment of one case of estivo-autumnal malaria who had a possible inherited lues, but with whom arsphenamin was not employed. These cases all gave *negative* Wassermann tests at the commencement of treatment, with the exception of one secondary luetic who gave a single plus. The other two secondary cases had previously given double plus Wassermann reactions, while the Bright's case had previously given one negative and one doubtfully positive Wassermann. The probable case of inherited lues had never previously had a Wassermann made.

And, further, at least two of these cases tolerated arsphenamin very badly, for one mercury in the form of inunction and by mouth affected the kidneys, and by one Potassium Iodide was not tolerated, even in extremely small doses. These points are of interest as they all tolerated *Mercurosal* very well.

A large experience while in the tropics with the treatment of lues without the, to me very doubtful, assistance of the Wassermann test, where the facilities for making this test did not exist, was the principal cause of a resort to another method of diagnosis and treatment control which I was then employing for the same purpose in connection with vaccine administration, and which I still employ, now in conjunction with the Wassermann in luetic cases, and with results that are very interesting, to say the very least, and which are not in favor of the Wassermann.



Suffice to say here, pending a coming communication dealing with this subject, that this test is dependent upon certain differential and numerical changes in the blood pictures taken before and after certain intravenous doses of antiluetic agents.

A passive experience with the intramuscular injection of the succinimide of mercury, and an active experience with the same mode of administration for other mercurial salts, with their extremely irritating local effects, to say the least; and, with insoluble salts, their slow absorption and, hence, prolonged effects after the eventuation of, especially, symptoms of renal complications, which latter are obviated not in the least by the oral administration of such remedies, had made me favorable to the intravenous method, given a salt of mercury less destructive to the blood than any that I had then tried.

*Mercurosal* in saline solution, and it readily dissolves, in as low a dilution as 0.3 gm. to 10 cc., produces much less coagulation of blood than does either neo-salvarsan or neo-arsphenamin in the same solution and dilution and, hence, allows the use of a small needle, with less likelihood of even the needle of smaller calibre clogging—in fact, I have never yet had this extremely annoying occurrence to happen with solutions of *Mercurosal*, which I cannot say about the other solutions, and it certainly causes very little local irritation when any of the solution happens to be expelled without the vein.

These points are all favorable to *Mercurosal*. And, although the *cell poison* effects following the administration of *Mercurosal* are plainly marked in the blood pictures, these necessary effects of all such therapeutic agents, even of distilled water, are, to say the least, no greater than those following either of the arsenical salts above mentioned, and very much less than those following the intravenous exhibition of any quinine salt I have ever employed. These are also desideratums, and greatly in favor of this salt in comparison with like effects following a similar exhibition of what other mercurial salts I have tried.

In comparison with the oral administration of mercury, and its employment by inunction, it is my opinion, from the observation of only two cases where ill effects were noted on the kidney, that these untoward symptoms of an inefficient elimination are less constant and pass off much more quickly, after the discontinuance of the remedy, with *Mercurosal*, at least when given intravenously,

than with other mercurials given either by mouth, by inunction or by subcutaneous injection. If this should really prove to be the case it is a consideration of very great importance, and one, in my opinion, which speaks well not only of the intravenous method of administration, but of this salt as well, and in the latter case in more than one way.

As to the efficacy of this remedy in comparison with its safety, let the case reports speak.

**Caes 1.** H. G. D., male, 19, had a lesion of penis nine months previously. Consulted his family physician who cauterized and dressed a few times; was also given three injections of "606," and pronounced cured. Consulted me for a malarial attack, when I got the foregoing history. Wassermann, single plus. Blood picture test strongly positive for lues. This case was treated for two weeks with neosalvarsan alone, in addition to his malaria treatment, during which time he was given six injections in doses varying from .3 gm. to .9 gm.

He then had two weeks of treatment with **Mercurosal**, .1 gm. every second day, seven injections in all.

During the second week he developed a slight diarrhea which may have been caused by the remedy or not. It passed off without any treatment. After a two weeks' rest from treatment the tests were repeated: Wassermann negative. Blood picture test positive. This case stopped treatment and went north, and it is only of interest in that it brought out some of the good points of **Mercurosal**, already mentioned; which at least acted as efficiently as any other mercurial would have done under the same conditions and for the short space of time it was employed, while it certainly caused the patient less inconvenience than would the subcutaneous, and myself less trouble than the intravenous injection of any other mercurial salt.

**Case 2.** O. L. F., male, 27, had a "soft chancre" two years previously for which he was given some sort of local treatment and some powders to take.

One year later, while in France with the A. E. F., a swollen testicle resulted in a Wassermann which was double plus. He was given three injections of **Salvarsan**, and ordered mercurial inunctions, under which treatment he greatly improved. Upon his discharge he was advised to continue active antiluetic treatment on his arrival home. This he neglected to do.

Six months later he consulted me for an ulcer of the glans penis, a secondary lesion, and requested "606" injections. Treponema positive by dark field. Wassermann negative. Blood picture positive for lues, very strongly so. First course of treatment, locally: Sterile dressings. Constitutionally: Two weeks of **Neosalvarsan**, 7 injections, .3 gm. to .9 gm. One month of **Mercurosal**: First two weeks, .1 gm. every second day; second two weeks, .15 gm. every second day.

With the larger dosage he developed diarrhea with abdominal pains, undoubtedly caused by the mercurial. The ulcer healed during the first week of treatment. He was then given two weeks rest from treatment.

Second course of treatment. Wassermann negative. Blood picture positive. Treatment for six weeks exactly as during first course. Diar-

rhea followed larger doses of *Mercurosal*. This was controlled by opium and the larger doses continued.

Third course of treatment. Wassermann negative. Blood picture positive. Eight weeks of practically a duplication of the above, first and second courses, but *Neosalvarsan* dosage slightly reduced. Patient could never take over .15 gm. *Mercurosal* without developing diarrhea and abdominal pains—controlled as above and larger doses continued. He was now given a month of rest from active treatment, and put on Potassium Iodide to tolerance.

Fourth course of treatment. Wassermann negative. Blood picture negative. Three injections, .6 gm. each, *Neosalvarsan*, at three day intervals. Six weeks of *Mercurosal*, .15 gm. at two day intervals. During the third course of treatment patient contracted scabies, which was marked by a slight eosinophilia and which yielded promptly to appropriate local treatment. During his fourth course he received treatment for a mild tertian malaria. He was put on Potassium Iodide and instructed to return in two months for further tests and possible treatment. He is about due.

**Case 3.** L. T., female, 30. Consulted me for "heart disease," but was found to have a malarial infection of the estivo-autumnal type. Stubborn progress under treatment for malaria occasioned a Wassermann. Wassermann negative. Blood picture doubtful. Treatment of quinine and arsenic for malarial infection was now supplemented with *Mercurosal* injections, .1 gm. every other day, until twelve doses were taken. Improved markedly both in appearance and general condition, but contrary to my advice, she stopped treatment. I do not think that any direct effects of the mercurial on the malaria was responsible for her improvement; but I am of the opinion that this subject had inherited lues, and that this was benefited by the *Mercurosal*, with a corresponding indirect effect upon the malaria through an increased resistance. Her blood pictures indicated this, very markedly so.

**Case 4.** P. S. G., male, 28. Had a "soft chancre" three years ago. Local treatment and pills were given. A suspicious iritis occasioned a Wassermann while with the A. E. F. and this showed positive. Was given a few injections of *Salvarsan*, with mercurial inunctions, and upon his discharge advised to follow this treatment under some competent physician until pronounced "cured." This advice he did not follow until, at the end of three or four months, the eye again became troublesome.

Wassermann negative. Blood picture very strongly positive. Eye condition pronounced one of luetic choroiditis by an ophthalmologist. A chronic posterior urethritis, Neisserian, was also diagnosed, as well as a benign tertian malaria. Had four courses of treatment.

This was undoubtedly a case of lues of nervous system complicated with malaria and a posterior urethral infection, if not of a deeper seat. His first real improvement was noted after his series of baths at Hot Springs. It is interesting from the fact that he simply could not tolerate Potassium Iodide without distressing symptoms of iodism, and could tolerate but small amounts of *Neosphenamin* without his renal function being very badly affected, while he could tolerate as high as .3 gm. doses of *Mercuro-*



sal of several doses before any ill effects were noticeable on the kidneys, but with no other effects of mercury whatever.

**Case 5.** J. W. H., 45. This case of Bright's disease before coming under my observation had shown two negative and one mildly positive Wassermann. He had been treated for lues, principally on account of an eye condition to the extent of three injections of .9 gm. each of Neosalvarsan, which made him "feel mean" for three days after each injection. His urine was loaded with cast of all kinds and showed considerable albumin.

Wassermann negative. Blood test doubtful.

Both the patient and his attending physician insisted upon injections of Neosalvarsan in large doses, and we finally compromised on small doses, but both refused to consider Mercurosal. I then made the further condition that he was to receive no other medication without my consent beforehand.

I treated this case for three months with twice weekly injections of Neosalvarsan, the dosage varying from .45 to .6 gm. with one of .75 gm. and one of .9 gm.

The effects from all of these injections, especially those upon the blood and the kidney function, were far from satisfactory, while those from the two large doses were to my way of thinking disastrous. To make matters worse, unknown to me, he was ordered and took for a few days rather large doses of Iodide of Soda with a mercurial salt. A hematuria promptly followed, while the casts always abundant were present in enormous numbers.

His white cell count had by this time dropped from its original 7000 average to 4000, and he now gave a + + Wassermann; while his blood picture test was still doubtful for lues. I now took matters entirely into my own hands and gave him three injections weekly of .1 gm. **Mercurosal.**

His first improvement was soon noted. His urine cleared of albumin, and blood cells and casts almost disappeared. He gained in weight and felt and looked much better. This treatment was continued for two months. He received in addition during this time three blood picture tests, with .3 gm. Neosalvarsan, each of which showed still doubtfully positive, and each followed by an increased number of casts and a return of red blood cells in the urine, while the leukopenia increased after each test.

The + + Wassermann I tried to assure him was due solely to the destructive action of the arsenical injections.

Before his departure for his home, a fourth blood picture test was made, .3 gm. Neosalvarsan, for I refused to give him more, and this was followed by an attack of high blood pressure. There was no opportunity given for a urine examination on this occasion.

Was this case luetic? I doubt it. The only benefit he received was from Mercurosal and small doses of mercurials, which are ancient remedies in such conditions as nephritis.

#### CONCLUSIONS.

The good points of Mercurosal have already been mentioned. The



case records speak for themselves—Mercurosal is evidently an active antiluetic agent, capable of less harm, at least when employed by the intravenous method, than some other mercurial salts employed orally, intramuscularly or by inunction.

It is apparently more rapidly excreted, at least when given intravenously, than are some other mercurial salts given by other methods, and possesses few of the drawbacks of other mercurial salts when given by the intravenous method.

I shall continue its use with care, and may be able to at least substantiate the good points, of my opinion, if not to add to these. It apparently supplies a need of antiluetic therapy.

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## PROCEEDINGS OF THE STAFF OF TOURO INFIRMARY

(HELD AT TOURO ON MARCH 18, 1921.)

DR. RANDOLPH LYONS: Case presented (X-ray picture shown). I will give you what I can from memory. (The patient is coming down). The case is that of a young man 18 years old. He never had any serious illness in his life; rather frequent colds. While a very young child, he had whooping cough, and chills and fever. One year ago, he had influenza. Otherwise, history negative. Denies venereal trouble.

The patient stated that two days before the present illness, he had lifted a good many logs. As a result of this, he felt very tired but nothing more. About two days later, while in bed, he had a sudden pain in the left chest in front from about the second to the fifth rib. The pain was rather severe and he felt somewhat short of breath. Pain did not last very long, finally disappeared and the patient went to sleep. He got up the next day apparently well, but during the morning while out walking, he was suddenly seized with an intense pain in the front part of the left chest. Pain was sharp and shooting in character, more severe on inspiration than on expiration, and was associated with marked shortness of breath and a sense of fullness in his left side. He had to go to bed but had no fever and gradually this pain became easier as days went by. The second attack began seven days ago. Up to the present time, the condition is a little over a week old. When I saw him three days ago, the pain had almost disappeared except when he breathed deeply. He was slightly short of breath and slightly cyanotic but able to walk. On physical examination, he showed

a marked bulging of the whole left side of his chest without any movement perceptible on deep breathing. There was no heart dullness nor apex beat visible on the left of the sternum. An impulse could be seen and felt about four inches from the median line on the right in the fourth interspace. On percussion, the whole left chest was hyperresonant. Right chest slightly hyperresonant. There was no heart dullness on the left but considerable on the right of the median line. On auscultation, no breath signs on the left; right side breath sounds exaggerated. Pulse pretty rapid and breathing moderately increased. Heart sounds audible to right of sternum in the fourth interspace.

I fluoroscoped him the first day alone. I am sorry I could not get the radiologists to be present. When I fluoroscoped him, his heart was considerably more dislocated to the right. (Picture hardly shows it.) The whole left lung seemed to be retracted near the vertebral column. No movement of the costo-diaphragmatic angle or diaphragm on the left could be seen. Heart could be seen pushed over to the right and beating somewhat to the right of the sternum. This picture was taken two days later and the patient was again fluoroscoped today. (Dr. Samuel will be glad to say a word about what we saw today). He has improved a great deal. You can still see the size of his heart. Visible impulse about three and one-half inches to right of mid-line; very little dullness to be made out on left side of sternum. The left side of the chest is more prominent than the right and does not move on breathing. (Auscultation will show most of the signs which I mentioned). What I diagnosed at first was "pneumothorax" of, so far, no known origin. Fluoroscopy bears this out. This condition is very unusual because almost every case of pneumothorax develops fluid of some kind and the majority (90%) are due to phthisis. The reason for the occurrence of fluid is that any perforation of the pleura allowing air to enter the pleural cavity is more than apt to carry infection (bacteria) with it. This causes an inflammation with exudation.

Perforation of the pleura may occur from the lung in tuberculosis from the rupture of a tuberculous cavity or pleural vomica. In non-tubercular disease from abscesses near the pleura, suppurating glands, gangrene, etc., all these conditions, however, carry infection with them and very soon after, the patient develops fluid

as well as air, depending upon the kind of infectious organisms present.

Pneumothorax has resulted from the rupture of a normal air sac after great muscular effort or such an affection as whooping cough. When rupture of an air vesicle occurs following severe exertion, it takes place during the time of great physical strain and not as in our case—two days later.

In the case here presented, there is no reason to suspect perforation of the pleura from disease of neighboring hollow organs (oesophagus, stomach, and colon) nor is there any question of a chest wound or needle puncture.

Hamman has recently stressed a benign, spontaneous, non-tubercular pneumo-thorax which occurs in apparently healthy persons without ascribable cause and resulting in no infection of the pleura and, therefore, no constitutional symptoms—healing rapidly and completely in a few weeks.

This type of Pneumothorax would correspond quite closely to our patient's case except for the fact that our patient presents a general, moderate adenopathy which is still to be explained and the X-ray shows a band of adhesions from the root of the lung to the periphery.

I might add here that the patient's laboratory findings were: Urine negative; Wassermann negative. Blood count: Whites, 4250; Reds, 4,666,000; S. M., 28; L. M., 7; N., 65; E., 0.

DR. E. C. SAMUEL: Presents under the fluoroscope, absolute absence of lung markings down here (picture shown) but across here (indicated on picture) a broad band extending from about this location here (indicated) out to the chest wall on the left side. The diaphragm moved fairly well on the right side with no evidence of pulmonary tuberculosis on the right side.

Dr. Weis brought up the question about the apex beat of this patient. We know this patient's heart is on the left side and the apex beat is not on the right side. This broad band of lung tissue extends straight across chest. The collapse above and below has not been seen in our department before.

The length of time between the two pictures was from Sunday and Wednesday—the picture was made on Monday morning after fluoroscopic examination.

#### DISCUSSION.

DR. J. B. GUTHRIE: (Case of Dr. Lyons). It is quite apparent

to me why the diagnosis of tuberculosis was not made at once in this case. The lesions are not apical and there is an area in the left lung at the base and at the apex which is of diminished density. Separating these, there is a band of increased density running across the left lung. This band is evidently the site of pleural adhesion which has protected the lung from complete collapse as a result of the pneumothorax. Rupture of the lung is much more frequent in tubercular subjects than otherwise and it is my opinion that tuberculosis is here the underlying cause.

DR. LEMANN: An interesting point in the history as related by Dr. Lyons is the fact that there were apparently two attacks and I would suggest that perhaps there was a rupture above at one time and another rupture below at the other time.

DR. LYONS: I want to explain that I may have said "apex beat" but I meant point of impulse. I think it was unfortunate that no Radiologist was present at the first fluoroscopy. The lung seemed more compressed at that time and the pleura contained more air. The physical signs and symptoms pointed to more tension three days ago than now. He had pain when he breathed and signs of fullness of which he complained then but not now. Dr. Lemann stated there had undoubtedly been two attacks. In the first attack, pain was not great and signs of shortness of breath, etc., did not compare to second attack—perhaps, because in the first attack, there was but a slight leak which may have been closed by adhesions, while the second rupture was more complete and allowed more air to get in. Valve-like apertures have been described in the pleura. My personal opinion is that it is quite possible this boy is tubercular and rupture probably occurred in the upper part of the left chest, the commonest place for ruptures. One argument against tuberculosis is the absence of fever at any time. The second point is that the majority of tubercular cases develop effusion but he is getting better all the time and has developed none so far. The question of tuberculosis will have to wait until air is absorbed, when the left lung can be examined.

DR. J. D. WEIS: I have a patient I really did not think I was going to show, but he is down here. I want to call your attention to him for the reason that he came to the hospital with an apparent condition which is commonly mistaken for a disease when it is only a symptom. I would like to read you a statement in the history: Complaint, "Bowel trouble." "Heart trouble," and the



story is "patient complains of bowel trouble." Says he has a diarrhea for five or six months; at times his bowels are regular, then they become very loose; a watery stool. At times he is bothered with a great deal of gas. Then his breathing is much embarrassed and he usually goes out in the open air to get relief.

This present attack came about 10 A. M. (about one week ago). He remained in bed because he didn't feel well. (I asked him what he means by "not feeling well" and his idea is typical malaise of anyone sick, weakness and desire to remain quiet.) He says that he has shortness of breath and after he has a great many bowel movements, he runs to the window. Belching gives relief. Patient says he has this trouble for about six years. He has not suffered so much with diarrhea except in the last six months. Past history negative. No operation. No diseases; denies all venereal history.

(Notice pallor and peculiar color!—He has what text-books call "Lemon pallor," and those of you who will see my fingernail in comparison with his will realize what I mean by "pallor").

Physical examination negative except that he has a loud systolic murmur in the pulmonic area. Liver is not palpable. Abdomen negative to pressure of any amount. Not sensitive in spite of all his diarrhea. No edema and no physical signs except pallor.

He is a carpenter. Never worked in lead. Has not a sore mouth. What I want to say is this; that diarrhea or loose bowels is not a *disease*. That is not the only thing I want to say. As to the cardiac side of this case; in other words, paroxysms, difficulty in breathing after he has had several movements of bowels do not indicate anything the matter with the heart! Organic pulmonic systolic murmurs are so rare, we practically disregard them for the present argument. Frankly, I did not know what the condition was until I saw a slide of the blood.

It is obvious that with a diarrheal condition and anemia as great to the eye as his, we could look upon diarrhea as a cause of anemia. Six months of intense diarrhea. His blood shows 1,315,000 red cells. His Wassermann is negative. Hemoglobin 28%. Blood color index 1.07. Now, one of the oldest things that I learned years ago when diseases of the blood were new, was that a high color index always meant an essential anemia. I mean pernicious anemia. Anything below one or fractions were characteristic of secondary anemia. It is a very good thing to hold to

still. It is a mighty good point in deciding. Peculiar lemon color skin which is unquestionably the result of hemolysis. It is because the skin carries the chemical result of hemolysis and the fat of the eye is yellow because it contains hemoglobin. In other words, "hemolysis" is the word. It occurs in secondary anemia, pernicious anemia. We know that in a great many instances, crises of pernicious anemia show temperature and diarrhea. After the diarrheal stage is over, the temperature usually declines, but nucleated red blood cells disappear.

While we were trying to make a diagnosis, we took slides down to the laboratory and almost no nucleated red blood cells were present. Blood shows typical poikilocytosis with an excess of macrocytes. The few nucleated red blood cells present show typical megaloblastic nuclei. After carefully hunting, we found a few of these nucleated reds and the typical vesicular nuclei. To my mind, this is typically pathognomonic of pernicious anemia. I don't believe that you can get as low a red blood count as this with a high hemoglobin and nucleated reds of this type in any other form of anemia and this is proven by the high color index. There are a few myelocytes in the blood which again confirm the essential type of anemia.

The whole picture then from the blood point of view is unquestionably one of pernicious anemia and this case is shown to bring out the point that such symptoms as "diarrhea," "heart trouble" although often treated as a disease are only symptomatic of a profounder organic trouble.

#### DISCUSSION.

DR. LYONS: I would like to call attention to the fact that sore mouth is quite common in pernicious anemia. It is not necessary to find nucleated blood cells in pernicious anemia. Macrocytosis is equally or more important and this is especially true of the patients on the upgrade.—If they are first examined during a period of improvement, the diagnosis then has to depend upon the history, the high color index with moderate distortion of red cells and macrocytosis—for one might examine five hundred cells and never come across a nucleated red.

DR. SIDNEY K. SIMON: In regard to Dr. Weis' interesting case, I would like to ask a question concerning the mouth condition. Last summer, three cases of Tropical Sprue came under my obser-

vation in each of which a severe grade of anemia was present. These cases presented, in addition, the usual clinical picture of sprue, including the sore mouth, the fat diarrhea, and malnutrition. Upon cursory examination, the cases, however, might have been regarded as pernicious anemia. In one, the hemoglobin estimation was as low as 40% and there was a red count of a little over a million.

About two years ago, E. J. Wood of Wilmington, N. C. called attention to the fact that many cases of sprue were entirely overlooked in the South, parading largely under the diagnosis of pernicious anemia. I would not wish to infer that Dr. Weis' case belonged under that category, but the point is worth noting, however, that in every instance where diarrhea is associated with a severe grade of anemia, the diagnosis of sprue should not be overlooked.

DR. J. D. WEIS: I think that such a blood finding as Dr. Simon presents would be unusual. 40% hemoglobin with 1 million reds would certainly never occur in secondary anemia. Just exactly how a Sprue case could produce such a type of anemia, I can't exactly explain. I agree entirely with what Dr. Lyons has said—that the diagnosis of pernicious anemia does not depend at all upon the finding of nucleated blood cells, but when nucleated red blood cells are present, the characteristic megaloblastic type of nucleus, that is of vesicular nucleus—is an essential fact and would prove anemia to be of the essential type. Also, the high color index is extremely important and this depends upon the fact that the predominant red blood cell is much above the normal in size and carries, therefore, more hemoglobin than normal. Rest in bed at once stopped the diarrhea in this case and it may be said in general, rest in bed is a remarkable therapeutic in pernicious anemia.

DR. RUSSEL E. STONE: Epiphyseal separation lower end of the femur. This happens in youth up to 16 years, sometimes up to 20 years. Ossification takes place after that. There are only about 220 cases reported in literature. Formerly, in compound fractures, they would resect and amputate. This case is one of a boy ten years old. Nothing in past history except multiple, comminuted fracture in same leg ten months ago. He was struck by an automobile and brought into the hospital with leg flexed, distortion of knee-joint. Free of pain, foot everted, except moving of parts. Set under anesthesia by extension and pressure over displaced

fragments; gradually flexion was reduced. (Putting leg up in semi-flexed position gets better results). Picture shows how it looked after reduction. Put up in cast for about twenty days. Semi-lateral view shown. No matter in what direction these patients are struck, there is always displacement of the epiphysis anteriorly and upward due to the attachment of the gastrocnemius muscle which pulls the shaft of the femur posteriorly; hence, the epiphysis moves in the point of least resistance. My opinion is that open operation should never be done. A number of authorities advise open operation. Under anesthesia, pressure over displaced fragment and flexion will always reduce the displacement. If the leg is put up in flexion, the results are usually good. Only two cases I have seen; boy 14 in 1918 of which I could not get picture.

I might add that in reducing fractures, it is well to watch foot for pinching vessel. It has happened but is always corrected by rearranging epiphysis.

#### DISCUSSION.

DR. J. B. GUTHRIE: I should be glad to learn from Dr. Stone what he considers the reason that the ancient treatment of patellar fracture led to ultimate amputation.

DR. ISIDORE COHN: Someone mentioned the question of operative intervention in Dr. Stone's case. Nothing can be worse than operation on developing joints. Operation means premature ossification of epiphysis; means limitation of growth in the long axis of the bone. Dr. Stone said use position of flexion, and I believe hyperflexion rather than semi-flexion more nearly approximates the shaft and epiphysis and renders the capsule more tense.

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#### ANALYSIS OF HOSPITAL SERVICE.

(Representing all discharges in February, 1921, excepting admissions prior to July 1, 1920.)

DEPARTMENT	Total	Cured	Improv.	Stat.	DIED 48 hrs.	TOTAL Dead.
Ear, Nose and Throat.....	121	90	24	6	1	1
Eye .....	10	5	4	1	0	0
Gastro-Intestinal .....	20	1	16	2	0	1
Gynecological .....	110	60	36	11	1	3
Medical .....	52	7	24	16	2	5
Neurological .....	20	0	11	9	0	0
Obstetrical .....	40	35	0	5	0	0
Newborn .....	28	28	0	0	0	0



Orthopedica .....	7	0	6	1	0	0
Pediatric .....	13	3	8	1	0	1
Skin .....	1	1	0	0	0	0
Surgical .....	160	87	47	19	2	7
<b>Total.....</b>	<b>582</b>	<b>317</b>	<b>176</b>	<b>71</b>	<b>6</b>	<b>18</b>

DEPARTMENT	INFECTIONS		DIAGNOSIS			Tent. not given	Consul- tations
	Instl.	On Adm.	Agree	Disagree	Addl.		
Ear, Nose and Throat ..	..	..	114	4	2	1	4
Eye .....	..	..	9	0	1	0	0
Gastro-Intestinal .....	..	..	15	3	1	1	0
Gynecological .....	1	..	93	6	9	2	2
Medical .....	..	..	35	12	2	3	10
Neurological .....	..	..	12	3	1	4	6
Obstetrical .....	..	..	39	0	1	0	1
Newborn .....	..	..	28	0	0	0	0
Orthopedica .....	..	..	7	0	0	0	0
Pediatric .....	..	..	11	1	1	0	1
Skin .....	..	..	1	0	0	0	0
Surgical .....	2	6	141	7	10	2	7
<b>Total.....</b>	<b>3</b>	<b>6</b>	<b>505</b>	<b>36</b>	<b>28</b>	<b>13</b>	<b>31</b>

Caesarian Section .....	6
Multiple .....	0
Breech, Footling, etc.....	3
High Forceps .....	0
Mid-Forceps .....	1
Low Forceps .....	5
Stillbirth .....	1

## NEWS AND COMMENT.

**STRAWBERRY WINE PERMIT GRANTED.** The Strawberry Growers Association of Louisiana was recently granted a permit by the prohibition unit to manufacture wine out of strawberries for non-beverage purposes. No sugar, however, can be added to increase the alcoholic content of the product. The strawberry growers had appealed to the department for permission to set up a winery to take care of their surplus crop, estimated to be worth about five million dollars. Under the Volstead Act it is lawful to establish wineries for the manufacture of products for sacramental or medicinal purposes. It is expected that producers of other berries will apply for permits.

**THE EYE SIGHT CONSERVATION COUNCIL.** Under the direction of the recently organized Eye Sight Conservation Council a nationwide "Save Your Sight" campaign is to be conducted. The aim

of the campaign is to acquaint the public with the importance of eye care and to urge the universal eye examinations of school children, workers in industries and clerks in stores and offices. Special literature will be sent to teachers, employers, and those especially interested in the advancement of efficiency and welfare in industry. Charts and posters are to be placed in school rooms and factories, visualizing eye care, depicting the advantages of correcting ocular defects and warning against eye strain and its attending evils. The Eye Sight Conservation Council is a membership organization, the directors and councilors of which are professional men representing various organizations devoted to health welfare, education, science and industrial betterment.

MEETING OF THE AMERICAN HOSPITAL ASSOCIATION. Announcement has been made that the annual convention of the American Hospital Association will be held at West Baden Springs Hotel, West Baden, from September 12 to 17. This Association includes both the association of the United States and of Canada and an attendance of 1000 to 1200 is expected, which will include hospital superintendents, trustees and surgeons. A feature of the convention will be an exhibit of hospital equipment and supplies of all modern improvements in surgical apparatus. In connection with the exhibit the Social Service Departments will demonstrate their various lines of work.

BIRTHDAY CELEBRATION OF DR. WILLIAM W. KEEN. Dr. William W. Keen, of Philadelphia, on the occasion of his 85th birthday, was given a testimonial dinner which was attended by many representative physicians and surgeons from all over the United States. A life size bronze bust of Dr. Keen was presented to him on behalf of the medical, civic and other organizations of many states. Dr. Keen has served as a medical officer in three wars and last fall presided over the International Congress of Physicians and Surgeons in Paris.

THE INTERNATIONAL HYGIENE CONGRESS which was to have been held in May at Geneva, Switzerland, has been abandoned on account of the low value of the currency of many countries and the high value of the Swiss franc and the fact that it was impossible to get Germany, Austria, Hungary, Czechoslovakia, Jugoslavia, Poland, Roumania and Bulgaria to send delegates, while it was also difficult even for France, Italy and Belgium to be represented.

UNITED STATES FORCES IN GERMANY HAVE HIGH DISEASE RATE. The Chief Surgeon in his report for 1920 gives a number of reasons for the greater incidence in venereal disease prevailing in the American forces in Germany, and gives one of the most important factors as the amount of money available for free spending. The private soldier in the American forces has received more pay in marks than some of the highest salaried officers of the German government, this being due to the difference in the exchange value of the American dollar and the German mark. As a result of this comparative wealth the "doughboy" has received unusual attention from prostitutes and the amount of drinking and the number of exposures to venereal diseases have increased.

PHYSICAL EDUCATION TO BE COMPULSORY FOR FRENCH YOUTHS. According to reports by medical boards who have been examining the class of 1921, which will join the colors next month, of more than 300,000 eligibles only 165,000 measured up to the ordinary physical standards. Doctors recommend the passage immediately of a law making physical education compulsory in all French schools.

AMAZON VALLEY TO BE EXPLORED FOR NEW DRUG PLANTS. An expedition having for its object the complete study of medicinal plants in the hope of adding to the laurels of American Pharmacy, will leave New York on May 1 for Northwestern Brazil to explore that great expanse of unknown country, where it is said that some interesting medicines are employed by the natives. The expedition will be led by Dr. H. H. Rusby, now Dean of Columbia University College of Pharmacy. Dr. Rusby is well known as an explorer in botanical fields and is responsible, among other successes, for the discovery of cocillana. It is to be hoped that this expedition, which is purely a pharmaceutical one, will add new drugs of value in the treatment of disease.

ACCIDENTS KILL MANY CHILDREN. The report of the Census Bureau shows that accidents are responsible for a larger portion of deaths under 14 than at any other period of life. The fact that 20,000 children are killed in the United States each year is one to be noted. This mortality is greater than that from measles, scarlet fever, whooping cough or diphtheria. Tuberculosis, which is looked upon as one of the principal causes of death in childhood, cause only 8.5 per cent of deaths between the ages of 5 and 8, while accidents

cause 16.7 percent. In the ages between 10 to 14, tuberculosis caused 14.2 per cent of deaths against 17.7 per cent by accidents. More than 4500 children under 15 were killed by automobile or other vehicular accidents in 1917, according to the 1917 Census Bureau Report and figures compiled by the First Aid Bureau of the American Red Cross.

**THE CAUSE OF ELEPHANTIASIS TO BE INVESTIGATED.** An expedition, consisting of six members of the London School of Tropical Medicine and led by Dr. Leiper, helminthologist, will soon start for the West Indies to investigate the cause of elephantiasis, with headquarters at Georgetown, British Guiana. The expedition is being organized under the auspices of Sir Patrick Manson and is at the request of the colonial office. It is proposed to segregate patients suffering from elephantiasis in rooms by themselves in which a number of mosquitoes are to be set free. After the patient has been bitten, the mosquitoes will be sorted out and an attempt made to discover which species transmits the disease.

**ROCKEFELLER FOUNDATION GIFT.** The Rockefeller Foundation has announced the gift of 43,000,000 francs as part payment on a total budget of 100,000,000 francs to be devoted to new buildings and endowment of the Medical School of the University of Brussels. Part of this fund is to go for a nurses' training school in commemoration of Edith Cavell and of Madame Depage.

**NEW MEDICAL JOURNAL.** *Psychobiology* and *The Journal of Animal Behavior* have been merged under the new name of *The Journal of Comparative Psychology* the first number of which is February, 1921. The *Journal* will be edited by Knight Dunlap and Robert M. Yerkes jointly. *The Behavior Monographs* will be continued, in association with the new *Journal*.

**LAKE CHARLES TO FIGHT MALARIA.** The commission council of Lake Charles has voted a sum of money to be used, with an equal amount to be provided, one-half by Louisiana and the other half by the International Health Board, to fight for the elimination of malaria.

**THE AMERICAN PROCTOLOGIC SOCIETY** will hold its twenty-second annual meeting in Boston, Mass., on June 3, 4 and 6, 1921. The profession is cordially invited to the public sessions.

**ST. RITA SURGICAL INFIRMARY.** This institution, which main-



tains about 35 beds, has an X-ray laboratory and an ambulance service as well as a diagnostic clinic and a consulting staff. Its doors have been thrown open to the reputable members of the medical profession of New Orleans for surgical and maternity work. Both Dr. Tilly and Dr. Menendez, its founders, are well known among the younger members of the profession, having served in the Charity Hospital during recent years.

THE ISADORE DYER MEDICAL FORUM, a student organization of the School of Medicine of Tulane University, met April 18 in the Hutchinson Memorial Building. This organization has been instituted to encourage research work among the students of the School of Medicine and has been named after the late Dean as a stimulus to good work on account of Dr. Dyer's well known activities in the medical and literary world. Papers by the following students were read: Blood Changes in Influenza, R. C. Scott, Class of 1921; Yellow Fever, Review of work of Noguchi, by Mr. J. Croce, Class of 1921; Post Operative Thrombosis, Embolism and Infraction, by H. Caplowitz, Class of 1922. Professors Matas and Bass addressed the meeting and participated in the discussion. The president of the organization is R. G. McMahon and the secretary, H. Caplowitz. The session was well attended and the entire proceedings were enthusiastically received by the students.

THE SHREVEPORT MEDICAL SOCIETY announces for its meeting on May 3 a "Symposium on Roentgenology." The various papers to be presented will be as follows: X-ray Therapy, by Dr. S. C. Barrow; X-ray Diagnosis, by Dr. C. P. Rutledge, with Dr. C. J. Willis, Sr., to open the discussion.

HODGEN LECTURES. The first of the annual Hodgen Lectures recently established by the Saint Louis Surgical Society, in honor of John Thompson Hodgen, the illustrious St. Louis surgeon, was delivered by Dr. Rudolph Matas, of Tulane University, on the evening of March 26, 1921.

BRITISH DRUG STORES confine their business almost exclusively to drugs, chemicals, sick room supplies and toilet preparations. Candies, ice cream, cigars, and the many other non-drug articles carried by almost every American drug store cannot be obtained in the "chemist shops." Special sales are almost unknown in the British retail drug business. There is no free telephone service and

the British drug stores need no liquor permits because they do not handle liquor. The tall ornamental bottles of colored water, red, green, yellow, familiar displays in American drug stores of yesterday, still have a place in British chemists' shops.

**TEXAS STATE MEDICAL ASSOCIATION MEETING.** The annual meeting of the Texas State Medical Association will be held in Dallas on May 10, 11 and 12. Active work looking to the perfection of plans to care for the entertainment of visitors is well under way. Men of prominence are on the program, local as well as among visitors, and the meeting will be full of interest and practical value, with some educational advancement at least assured. For years the Texas State and the Oklahoma State Medical Associations have held their meetings at conflicting dates, but this year the Oklahoma Association has consented to hold its meeting a week later so that members wishing to take advantage of both meetings can do so without embarrassment or confusion. As the coming meeting of the Texas State Medical Association will be legislative meeting, the profession as a whole will be more interested than ordinarily.

**AMERICAN MEDICAL EDITORS' ASSOCIATION.** The 52nd annual meeting of this association will be held at the Hotel Lenox, Boston, Mass., on Monday and Tuesday, June 6th and 7th, under the Presidency of Dr. H. S. Baketel, Editor of the Medical Times.

A novel feature of the literary program will be introduced this year in the shape of symposia, which will be discussed by various members. The subjects will be: "Group Practice and the Diagnostic Clinic;" "What Should be the Attitude of the Profession Toward Health Centers;" "The Correlation Between Editorial, Advertising and Subscription Work."

Every doctor, even remotely interested in medical journalism, will find it to his advantage to attend, and is most cordially invited.

**RADIUM NUMBER OF MEDICAL REVIEW OF REVIEWS.** The June issue of the *Medical Review of Reviews* will be a special radium number devoted to Mme Curie. The issue will consist exclusively of articles on radium and its uses, written by prominent radiologists in the United States and Canada. Copies will be sent complimentary to every physician interested in the uses of radium and readers of this item who desire that issue may have it by asking the Medical Review of Reviews, 51 East 59th Street, New York.

THE PHYSIATRIC INSTITUTE, of Morristown, New Jersey, has been established for the treatment and investigation of metabolic disorders, especially diabetes, obesity, nephritis and high blood pressure. The purposes of the institute are scientific and philanthropic, and treatment is offered to suitable patients in all degrees of financial circumstances. Some support for the charitable and scientific work has been obtained, but an appeal is made to all persons interested for more funds to place the new institute on a safe basis and aid in the development of a branch of medicine in which the possibility of important therapeutic advance has already been demonstrated.

PERSONALS. Dr. Robert T. Lucas, Tulane 1918, is now located at Shreveport, Louisiana, with offices in the Ward Building, and is limiting his practice to Diseases of Children.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

**The Duodenal Tube And Its Possibilities**, by Max Einhorn, M. D. W. B. Saunders Company, Philadelphia, 1920.

In chapter one, Einhorn speaks of the duodenal tube and its congeners. Of one of these I am able to speak, namely, the tube. The metal spiral tube devised by Kuhn in 1898, I used in 1903. I used this tube on several selected cases. At that time I thought, and with the present information before me I am reasonably sure now, that the instrument passed through the pylorus into the duodenum. This instrument has its drawbacks and is awkward to manipulate. The duodenal tubes used at present are free from the objectionable feature of the Kuhn tube.

At present there are in use tubes the tips of which differ somewhat in shape. Then we have the tube with the catheter end first introduced by Einhorn in 1909. I frequently use such a tube, also the one known as the Jutte tube. The more general use of the duodenal tube for diagnostic purposes bids fair to add to our knowledge of the changes incident to pathologic processes in regions now made accessible by its use. Its use should also make possible more rational therapy, but until we have determined more definitely what can be accomplished, the practitioner should be cautious in his statements as to results. Einhorn has

presented us with a timely text well illustrated. Its perusal is well worth while.

STORCK.

**The Roentgen Diagnosis of Diseases of the Alimentary Canal**, by Russell D. Carman, M. D. W. B. Saunders Company, Philadelphia, 1920.

The importance of roentgenologic examination of the digestive tract as a practical aid to gastro-intestinal diagnosis is now recognized by all progressive practitioners. Dr. Carman as head of the Section in Roentgenology, Division of Medicine, Mayo Clinic has been afforded exceptional opportunities of which he has fully taken advantage.

The book reveals the work of the careful, conscientious worker, conservative in all his statements. As an example of this conservatism, we instance chapter XVIII, "Gall-Stones and Diseases of the Gall-Bladder and Liver." A careful reading of this chapter will prove profitable to internist and surgeon alike.

This book is deserving of a large circle of readers.

STORCK.

**Surgery. Its Principles and Practice. For Students and Practitioners**, by Astley Paton Cooper Ashhurst, A. B., M. D., F. A. C. S. Lea & Febiger, Philadelphia and New York, 1920.

The author, just returned from his military service, has thoroughly revised his first edition, much of which is rewritten and rearranged. His recent experiences in army hospitals is well reflected in the text in his adaptation of this knowledge of civil surgery.

It is impossible in a book of this size to cover thoroughly the ever increasing field of surgery and the author has done well to briefly touch upon such subjects as local and spinal anesthesia, X-ray, radium, etc., as such subjects have now reached the dignity and importance of requiring special text-books. This space has been well conserved and in many regions is well covered and often equals that found in the more elaborate systems of surgery.

The sections on gunshot wounds, infected wounds, Carrel-Dakin treatment, fractures, shock, empyema, hernia, surgery of the pancreas, hydrocephalus and carcinoma of the tongue will be found particularly interesting. In the section on carcinoma of the tongue the author describes his own operation.

The text is unencumbered with bibliographical references but dates are furnished to facilitate a more ready reference to authoritative contributions. The specialities, Eye, Ear, Nose and Throat are naturally omitted while gynecology, orthopedic and genito-urinary surgery are discussed only so far as they come within the province of general surgery.

The sections on kidney and prostatic surgery are particularly good.

Many of the illustrations are original and excellent, drawn from the author's large clinical experience.

The index is well arranged and quite thorough. The edition shows careful and extensive revision and is quite attractive, readable, reliable and up-to-date and is to be recommended to both students and practitioners.

ALLEN.



**A Text-Book of Histology**, by Frederick R. Bailey, A. M., M. D. William Wood & Company, New York, 1920.

This text has long been accepted as one of our standard texts for reference and student work. The author has augmented the chapter on neuro-histology which branch has developed so greatly in recent years. The book is well arranged and is replete but not too voluminous to render the information readily procured. It is also extensively illustrated.

The knowledge of histology has among its most important objects to form a basis for the appreciation of pathological changes. For this reason it has always appeared to the reviewer that more stress could be placed on minute normal factors in cells and tissues and the relative proportions of framework tissues and parenchyma. This could be carried on throughout the text or in chapter form. The reason for such a suggestion is that while the average student may possess a general knowledge of the names of structures, the more detailed factors upon which they are to base their pathological studies, such as cell degeneration, cells of inflammation, interstitial tissue increase, etc. are not appreciated by them. This phase of the discussion is intended for texts of histology in general as well as the present text.

W. H. HARRIS.

**Chemical Pathology**, by H. Gideon Wells, Ph. D., M. D. W. B. Saunders Company, Philadelphia and London, 1920.

The original edition of this text represented a much needed and important connecting link between the various pathological processes of the human body and the physiological chemistry associated therewith. Its subsequent editions have been augmented and elaborated. It enters not only into the chemistry of the phenomena of disease but also the consideration of the physics where indicated. The interesting and intricate chemical and physical factors concerned in the remarkable occurrences found in immunological reactions are also freely discussed.

The extensive bibliography of this work together with the extensive amount of information in its own text, renders it of great value to those seeking such knowledge or investigating problems bearing on such subjects.

While the scope of this book is beyond the medical student, it is certainly of the greatest value to the teacher and investigator.

W. H. HARRIS.

**Compend of Diseases of the Skin**, by Jay Frank Schamberg, A. B., M. D. P. Blakiston Sons & Co., Philadelphia.

Dr. Schamberg's *Compend of Diseases of the Skin*, 6th edition, is well illustrated, contains many useful formulas and is in every respect a very useful book for its size.

MENAGE.

**MORTUARY REPORT OF NEW ORLEANS.**

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for March, 1921.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	1	2	3
Intermittent Fever (Malarial Cachexia)		1	1
Smallpox	1	3	4
Measles	3	1	4
Scarlet Fever			
Whooping Cough		1	1
Diphtheria and Croup	1	1	2
Influenza	1	4	5
Cholera Nostras			
Pyemia and Septicemia		1	1
Tuberculosis	31	24	55
Cancer	29	7	36
Rheumatism and Gout	2	1	3
Diabetes	4	1	5
Alcoholism			
Encephalitis and Meningitis	4	2	6
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	18	8	26
Paralysis	4	3	7
Convulsions of Infancy		3	3
Other Diseases of Infancy	8	7	15
Tetanus			
Other Nervous Diseases	5	3	8
Heart Diseases	57	23	80
Bronchitis	2	1	3
Pneumonia and Broncho-Pneumonia	28	32	60
Other Respiratory Diseases	2		2
Ulcer of Stomach	1	1	2
Other Diseases of the Stomach	1	1	2
Diarrhea, Dysentery and Enteritis	13	6	19
Hernia, Intestinal Obstruction	2	1	3
Cirrhosis of Liver	3	5	8
Other Diseases of the Liver	4		4
Simple Peritonitis	1		1
Appendicitis	2	1	3
Bright's Disease	11	7	18
Other Genito-Urinary Diseases	11	11	22
Puerperal Diseases	9	7	16
Senile Debility	1		1
Suicide	6	1	7
Injuries	28	18	46
All Other Causes	28	12	40
<b>TOTAL</b>	<b>322</b>	<b>200</b>	<b>522</b>

Still-born Children—White, 17; colored, 13; total, 30.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death rate per 1000 per annum for Month—White, 13.32; colored, 21.82; total, 15.66. Non-residents excluded, 13.44.

**METEOROLOGIC SUMMARY (U. S. Weather Bureau).**

Mean atmospheric pressure..... 30.11  
 Mean temperature . . . . . 71.  
 Total precipitation . . . . . 5.59 inches  
 Prevailing direction of wind, south.

# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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EDITOR: CHAS. CHASSAIGNAC, M. D.

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## EDITORIAL

### NON-SPECIFIC THERAPY.

How medical ideas and practices, like all others it might be said, run in cycles is well illustrated by the attention which has been given within the last few years to the question of the non-specific reaction.

As far back as we can go there were the cautery, the seton, the blister, the sinapism—all considered most potent measures in their day. They were displaced and pushed aside, declared useless, even, as more specific methods were introduced and specific therapy was developed.

For many years attention was concentrated upon efforts to multiply the agents to be used in the application of this specific therapy. Then, perhaps on account of the enormous number of specific agents required to combat the almost unlimited number of

specific causes of disease, or because of the frequently disappointing results of such specific medication, a return to non-specific therapy followed, the attempt to stimulate the entire organism and increase its resistance instead of controlling directly the agent causing the disturbance.

Many types of substances were used and had their vogue in turn: the vaccines, applied in a general or non-specific manner; the protein split products, various chemicals, etc. And a surprising thing is that they all proved more or less efficient clinically. Many theories have been advanced in explanation, but it is not our purpose to discuss them at this time, especially as the literature on the subject is abundant and accessible.

One of the details which is interesting to us, as tending to show how little is new under the sun, is the recent introduction of deep injections of turpentine for overcoming serious infections. Touatre, in his excellent clinical study of yellow fever, published in 1898, in this city, quotes Fochier, of Lyons, as recommending the use of turpentine injections in the fight against grave systemic infections.

This *new* idea was getting old more than twenty years ago.

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### PEACE AT ANY PRICE.

The tendency and demand is for the "peace at any price man" in medical assemblies without a realization "peace" may have its detracting effect upon scientific progress. "What's the use of having ignorance if you can't show it?" It astonishes many of us sometimes when the supposed ignoramus decides to speak. His method may be crude but he often springs a surprise which is very enlightening.

Let us not approve of any method that tends to strangle discussion by encouraging only the *savant* to speak, though it produces great harmony at meetings; on the contrary we should hear from others than the trained teacher. Honeyed praise for a contribution need not be always welcome; we should have controversy and enlightenment when procurable.

Medical men are finding it difficult to increase the attendance at meetings simply because they are confronted with contributions which they dare not refuse to accept. They feel that should they lack the genteel and conventional manner of speech in discussing,



they will be thought an antagonistic. Individuality then is hidden for the sake of peace.

Shall we in this age of progress merely cajole and flatter? If the aim in medical organization is to be constructive and elucidating then, let us not have "peace at any price."

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### THE SURGEON GENERAL'S LIBRARY.

Expression on the part of many at the State Medical Society Meeting shows a desire for a medical circulating library. The thought is an excellent one and the plan will be of benefit to the members. It will gain for the local organization an increased number of volumes in its library and it will offer an attraction for drawing new members into the State organization.

It is apropos at this time to call the attention of our readers to the existence of the Surgeon General's Library at Washington. The number of volumes contained in this library is tremendous. These books are procurable through what is known as the inter-library loan. It is the policy of that institution to loan to medical men throughout the United States through the medium of their local library. The transportation charges are paid both ways by the borrower.

There is a file of the "Index Catalogue" of this library at many places and also of the "Index Medicus" which is published by the Carnegie Institute. It is truly astonishing how convenient it is to obtain valuable information once you have become familiar with the plan.

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## ORIGINAL ARTICLES

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(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

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### MISSED ABORTION.\*

By E. L. KING, A. B., M. D.

(From the Department of Obstetrics and Clinical Gynecology, College of Medicine, Tulane University of Louisiana.)

The term "missed abortion" was first used by Oldham in 1847, but the various writers on the subject since then are not yet fully agreed as to the conditions to be fulfilled in order for a case to be classified under this heading. Frankel restricts the definition to cases of intrauterine fetal death, prior to viability, with the complete retention of the uterine contents to or past the calculated date of delivery. Duncan broadens this to include *all* cases of fetal death before term, which go to or past the nine month period. Barnes says that the term missed abortion is abused. "for, as McClintock puts it, every woman who is delivered at term may be said to have missed aborting." He (Barnes) prefers to call this condition "concealed abortion." Litzenberg in a recent paper, gives a very good and comprehensive definition. He says "the term missed abortion is now applied to all cases of death of the fetus *in utero* before viability with no effort at expulsion within the usual time of an ordinary abortion." After viability, the condition would be called missed labor. This definition does not demand that the uterine contents should be retained past the calculated date of delivery, as do those of Frankel and Duncan, nor does it appear that this should be prerequisite. Litzenberg puts "the usual time of an ordinary abortion" as being anywhere from the death of the fetus to a period two months later; if expulsion occurred after that time, he would class it as a missed abortion.

From the paucity of the literature, one would judge that the condition is not frequently encountered. Williams refers to the "rare cases of missed abortion" on one page (pg. 401); on another page (pg. 672) he states that "the condition occurs . . . .

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\* Read before the Orleans Parish Medical Society, April 11th, 1921.

comparatively rarely in women. 70 cases were collected from the literature by Graefe in 1896, and 105 by E. Frankel in 1903, though I am convinced from my own experience that such figures give a very inadequate idea of its incidence." Reference to the older text-books bear out this contention, though the term itself is not used. Chailly's *Midwifery* (1844) refers to "prolonged retention of the dead fetus." Sir J. Y. Simpson, in 1855, reported several cases. By a strange coincidence, articles were published in different journals on this subject in February, 1921, by Litzenberg and by Rongy and Arluck, who reported 13 and 21 cases, respectively. Six cases have come under my own observation in the past four or five years. So it would appear that the occurrence of missed abortion is not a rarity, but that the correct diagnosis of the condition is. Failure to recognize the true status of affairs may at times entail very serious physical consequences for the mother. Again her reputation may be at stake in case an abortion occurs a considerable time after separation from or death of her husband.

Two factors come into play in the etiology; first, fetal death, second, the failure of the uterus to expel the dead fetus. The causes of fetal death are legion, and we are not always able to discover the causative factor in a given case. Many theories are advanced to explain why the uterus does not contract and expel what has become a foreign body. Lessened irritability of the uterus is the theory proposed by Litzenberg, though we are as a rule at a loss to explain why this should be. He leans to Frankel's theory that final expulsion is due to the congestion consequent upon returning menstruation. Rongy and Arluck believe that one of two things may occur. First, slow changes at the placental site may cause early fetal death, but the product of conception does not become a foreign body until the major part of the placenta is affected. Second, fetal death may be primary, from various causes other than placental, and the placental changes are secondary and gradual in onset. Cases have been reported by Simpson and others in which the placenta has continued to grow for some time after the death of the fetus. In other words, according to this theory, the product of pregnancy becomes a foreign body only when the placental degenerative changes are far advanced, and then it is no longer retained, but is expelled.

At first sight, it would seem that retention of the dead ovum for weeks or months would affect the mother's health, but in the

absence of infection the mother often, but not invariably, appears to be in good general health. Chailly says that prolonged retention is harmless provided the membranes are intact, but not otherwise. Practically all modern writers emphasize the point that a dead fetus may be retained for a long period of time without deleterious effect upon the mother. There is a limit to all things, however, and sooner or later indefinite symptoms of a mild toxemia will appear; if infection of the uterine contents occurs, the picture of sepsis will of course be presented.

Several things can happen to the uterine content after fetal death<sup>1</sup>. It may undergo little change other than absorption of amniotic fluid and of some of the body fluid of the fetus, thus giving it an emaciated, shrivelled appearance;<sup>2</sup> it may become surrounded by effused and clotted blood and become a "blood mole";<sup>3</sup> as a result of fibrin formation, the "blood mole" may be converted into a "fleshy mole";<sup>4</sup> it may be compressed and mummified and then be retained for a long period;<sup>5</sup> it may rarely be converted into a lithopedion, which is generally retained indefinitely;<sup>6</sup> it may undergo extensive maceration;<sup>7</sup> septic infection may occur;<sup>8</sup> rarely, skeletonization of the fetus may occur, with very rare instances of perforation of the uterus by the bones;<sup>9</sup> in early pregnancy, the ovum may be partly or wholly absorbed;<sup>10</sup> occasionally, in twin pregnancy, one grows at the expense of the other, which dies and is found at delivery flattened out in the membranes (fetus papyraceous). Simpson in 1855 reported a case in which one fetus of a triplet pregnancy suffered this fate, the other two being delivered at term as living infants.

The diagnosis is not as a rule made on first sight, but should not be especially difficult if the possibility of the occurrence is borne in mind. Observation for a considerable period and careful, repeated vaginal examinations are requisites. It may not be possible to make a positive diagnosis until four to six weeks have elapsed. The patient may present practically no subjective symptoms, and may seek advice because of evident lack of progress of the gestation, flabbiness of the breasts, etc. Often she also complains of symptoms of mild toxemia, such as malaise, loss of weight, poor appetite, dull headache and afternoon fever. Litzenberg stresses the fact that missed abortion is a frequent cause of afternoon rise of temperature. There may be a history of a threatened abortion which was apparently averted. Vaginal examination will



reveal a uterus not corresponding in size to the supposed duration of pregnancy, but smaller, and of a peculiar doughy consistency. There may be a dark, sanguineous discharge. Repeated examinations will show that the uterus has not increased in size, but may have actually become smaller. Jellett states that in some cases there is just enough slow bleeding to cause the uterus to enlarge at the same rate as if pregnancy were advancing normally. The temperature of the cervix is the same as that of the vagina, whereas in normal pregnancy it is about one degree higher. Polak states that peptonuria and acetonuria are constant phenomena. Irregular hemorrhage may occur; in one of my cases, it was sufficiently regular for the patient to mistake it for the menstrual flow, and she was very much astonished when she aborted later.

The prognosis is, as a rule, good, and the dead ovum will in most cases be expelled sooner or later. While, as above mentioned, prolonged retention without detriment to the mother is common, we must always bear in mind the danger of varying degrees of invalidism from toxemia, the risk of infection of the uterine contents and consequent sepsis, and the possibility of the occurrence of serious (and, in rare cases, fatal) hemorrhage. The latter may occur either before or after the evacuation of the uterus, especially after, due to its deficient contractile power.

From the above, we can see that, when the diagnosis is once made, the indications for emptying the uterus are clear. This may be accomplished by resorting to the usual methods. In the first two to two and one-half months the contents can generally be removed under anesthesia at one sitting. Few cases will be encountered this early in pregnancy; as a rule, the pregnancy will have advanced to the third or fourth month before fetal death ensues. Hence the usual treatment will be to bring about uterine contractions by the use of the pack, bougies or catheters, bags, etc. Occasionally, vaginal hysterotomy may be necessary. Rongy and Arluck stress the point that instrumentation must be very carefully preformed, on account of the danger of perforation, as the placenta may be rather firmly adherent and the uterine wall may be abnormally thin and friable. Due to changes in this wall and its consequent lack of contractility, hemorrhage after evacuation of the contents may be profuse, and at times so intractable as to necessitate a rapid hysterectomy, preferably abdominal. If the diagnosis is first made at or near the expected date of delivery,

and the patient is in good condition, we may temporize, hoping that contractions will ensue at that time. As a rule, the patient's best interests will be served by evacuating the uterus as soon as the diagnosis is established. In four of the six cases detailed below, however, delivery was spontaneous.

**Case 1.** Admitted to the Charity Hospital in 1918, supposed to be about six months pregnant. Repeated examinations over a period of several weeks showed a uterus about the size of a three months' pregnancy, of characteristic consistency, which did not increase in size. Her general health was good. It was decided to induce labor, but the night before the scheduled operation she aborted a three months fetus, which was emaciated and slightly macerated.

**Case 2.** This patient was seen late in December, 1919; complaint, irregular bleeding. She stated that she menstruated in June; in October, November, and December she bled a few days each. She thought that this was normal menstruation, and decided that her first diagnosis of pregnancy was an error. On examination, the membranes were found to be bulging from the cervix, and the uterus was about the size of a three months pregnancy. She was sent to the hospital, and aborted that night. The fetus was flabby and shrivelled, and corresponded in size to a gestation of three months. The patient was in good health, and had continued her usual work up to the day on which she was first seen.

**Case 3.** Consulted me in the spring of 1920, stating that she was about seven months pregnant, and was desirous of arranging for confinement. The uterus reached about one-half the way to the umbilicus. She was told that she had probably miscounted. Repeated examinations revealed the uterus at a standstill. Active treatment was considered, but the patient spontaneously aborted a macerated fetus of about four months. This patient had been separated from her husband for four months, and just escaped the unfounded charge of immorality.

**Case 4.** Admitted to Charity Hospital in March, 1921. Last menstruation in May, 1920; calculated date of delivery, February, 1921. Patient was very defective mentally, and no history as to quickening, fetal movements, etc., could be obtained. The fundus was just above the umbilicus. No fetal heart sounds, movements, or other signs of fetal life were obtained. Death of the fetus was diagnosed. After a few days in the hospital, a one and one-half pound, somewhat macerated fetus was delivered spontaneously. The Wassermann reaction was negative.

**Case 5.** This case occurred in the practice of Dr. C. Jeff Miller. The diagnosis of fetal death at about three months was made three or four months after death had taken place. The patient was etherized and the uterus was emptied at one sitting.

**Case 6.** Also a case of Dr. Miller's. Fetal death had taken place at approximately five and one-half months, and the uterine contents had been retained for about three months thereafter. Cervical dilatation was brought about as usual, and when complete the fetus and the placenta were removed under ether. Bleeding was free and the uterus was tamponned. She bled profusely in spite of this, however, so a rapid abdominal hysterectomy was performed, but the patient died shortly after leaving the table.

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## DISCUSSION.

**Dr. J. S. Hebert:** I am very sorry that I did not get here in time to hear the beginning of the paper, as this is a very interesting subject. However, Dr. King has gone over the subject thoroughly; yet, I wish to emphasize the two factors which were absolutely necessary for the condition to be present: 1st. Death of fetus, 2nd. Failure of uterus to expel same.

As to the diagnosis I wish to also emphasize these two points: 1st. It must be definitely established that cessation of growth of the product of conception has taken place. 2nd. *Pari passu* with death of fetus, the uterus has ceased to grow.

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## CORRECTIVE RHINOPLASTY, WITH PRESENTATION OF A CASE.\*

By DR. ARTHUR I. WEIL.

The case which I am presenting to-night is, I believe the first subcutaneous corrective rhinoplasty done by a Louisiana Surgeon, and as far as I am aware is the first done by any in the Gulf States, though it is possible that others have been done of which I am ignorant. The work is now being done extensively in the East and North, with results eminently gratifying to surgeon and patient, and with marked improvement in the appearance and a consequent cheerfulness and well being of the patient his earning capacity is sometimes materially increased by the operation; for we all know that physical deformity resulting in the ridicule of companions, in self consciousness and embarrassment and often sullenness and truculence is not conducive to efficiency or productiveness in a workman. Those who have had a large experience in this work report numbers of instances of increased productiveness as well as increased happiness among their patients.

Formally it was considered necessary to preface a paper describing this operation with a pseudo apology. For a surgeon to devote his skill and energy to a technique designed solely to the improvement of the cosmetic and not the physical well being of

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\* Read before the Orleans Parish Medical Society, April 25th, 1921.

his patient seemed anomalous. It seemed too much like usurping the field of the "beauty doctor". But the above mentioned results have more than justified the work and the operation is now well entrenched in the field of surgery. If such a large part of the war surgeon's efforts were devoted to remedying the mutilations of battle, why not equally important the effort to correct the deformities of nature?

The pioneer in this class of work in America, was Roe, of Rochester, N. Y. Indeed I believe he was the first surgeon anywhere to do the subcutaneous nasal correction. He was followed by Joseph, of Berlin, and since then the work has been taken up by numerous surgeons of this country, among others Cohen of Baltimore, Tieck of New York and Beck of Chicago. I have seen all three of these men work and I wish herewith to testify my indebtedness to them for their help and instruction in preparing myself for this work. The good results which I have seen from their operations has been the chief incentive to me to take up their work in this virgin field.

"Corrective rhinoplasty," as defined by Cohen, "concerns itself with those operations which have for their object the restoration to a presentable form, size and position noses which from accidental or congenital causes, are so deformed as to give the individual an unsightly appearance. The deformities may be divided into two classes. 1. Idiopathic or congenital. 2. Acquired. To the former belong the over developed nose, hump nose, congenital saddle and pug nose, while to the latter belongs all sorts of grotesque alterations in shape and position of the nose caused by fracture or dislocation and likewise by the destruction of the bony or cartilaginous framework from syphilis, tuberculosis and lupus."

"For practical purposes a further classification may be made into deformities affecting the bone and those affecting the cartilaginous portions of the nose. though it frequently happens that both are involved at the same time."

By various modifications of the operation here described, the several classes of deformities can be corrected; a hump on the nose may be removed, a hooked nose made straight, and oversized nose reduced, a laterally deflected nose straightened, a too long nose can be shortened, a flattened or saddle nose elevated, etc.

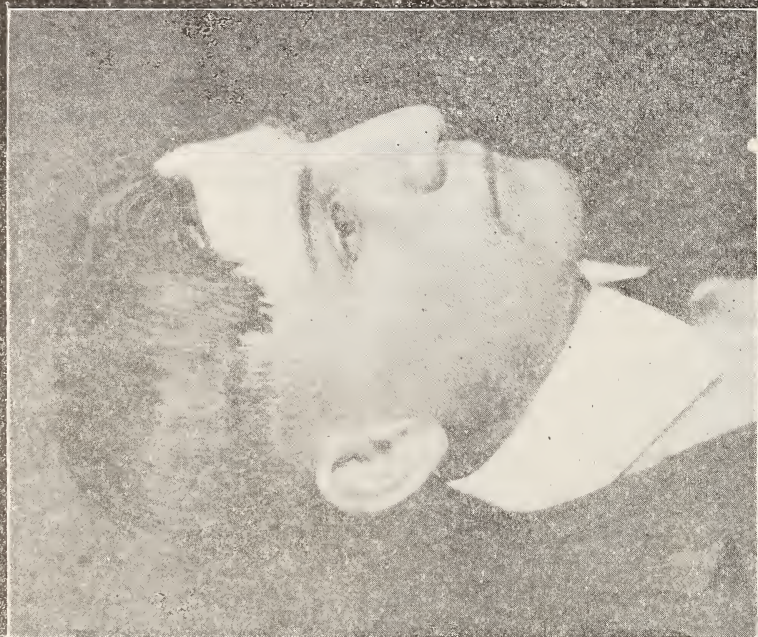
The purpose of the present report just now when I have only one case to present, is not so much to report the individual case



as to call your attention to the possibility of correcting such deformities; for there are doubtless numbers of patients of your acquaintance who are suffering under the handicap of various nasal malformations and who are ignorant of the possibility of their correction by a comparatively simple and safe operation, with the promise of most satisfactory results.

Sometime in the future I hope to be able to report to you a series of these cases, comprising the various classes of deformities which I shall have corrected. For the present I shall content myself with showing the one case, with a brief description of the operation and presenting the patient here to-night so that you may be the judges of the result. The accompanying photographs will show the shape and contour of the nose before operation. You will note that there is a large hump on the nose, which shows fairly well in the photograph; in addition there was a marked lateral deflection of the nose which made the nose very unsightly, but which cannot be well seen in the photograph. The operation was done on April 12 which is less than two weeks ago and the swelling as you see has not entirely subsided. In the course of a week or two more when the swelling has completely disappeared, the nose will look even better than it does now. You will note that the lateral deflection is practically entirely corrected and the nose is now straight. Of the hump also there is very little left and the contour of the ridge of the nose, though slightly curved presents no disfiguring hump as it did before. It might be mentioned in passing that since this was my first operation of the kind, I was possibly a little overcautious, and, fearing to remove too much of the hump, I may possibly have left just a little more of it than was advisable. This is a mistake which can be easily avoided in further operations, though I am inclined to believe that conservatism in these operations is not altogether a bad fault.

When the patient first came to me for relief he complained, in addition to his deformity, of almost complete nasal obstruction. He was compelled to breathe almost entirely through the mouth. Indeed this complaint very frequently accompanies nasal malformations, especially in those types where there is lateral deflection of the nose. The obstruction is due, practically always, to a deflected septum and it is necessary to correct this by a submucous resection preliminary to the cosmetic operation. This is one reason why the rhinologist is better fitted for these operations than the



Three Weeks After.



Before Operation.

general surgeon. In this case a preliminary submucous resection was done, being careful however to leave as much bone and cartilage behind as possible so as not to weaken the support of the nose. Since the submucous resection, the nasal obstruction is removed and the patient says he can now breathe freely through the nose.

Now follows a brief description of the operation which may be taken as a type; the operations for the other classes of deformities being modified to suit the individual case, whether it be the reduction of an oversized nose, a rib or other bone implant to correct a sunken or saddle nose and the like.

It is necessary that the operation be performed under the strictest aseptic precautions, for infection is the one complication to be feared. This is true in all classes of rhinoplasties but especially in rib or other bone implants for it is readily understood that infection would cause the imbedded bone to slough away and destroy the cosmetic result. The nose and whole face are thoroughly cleansed with soap and water, ether and alcohol. I prefer this to iodine, for after the operation the nose has to be covered for a considerable time by a metal splint to be described later and iodine might irritate the skin and cause maceration from the long contact with the splint. The nose is douched several times with warm sterile saline or boracic acid solution. The hairs in the nasal vestibule are cut off short with small sharp pointed scissors and the nasal vestibule is carefully cleansed with 1 to 5000 bichloride and alcohol or wiped with iodine. To prevent infection from the nasal secretions, especially when operating under general anesthesia which stimulates secretion of the mucus, it is necessary to insert a post nasal tampon to enforce mouth breathing and to pack the nostrils with sterile gauze. This is also of great assistance in preventing blood from running back through the nose into the throat to be aspirated by the patient. Where the operation is done with a local anesthetic it is sufficient to pack the posterior part of the nostrils with sterile gauze. The operator and assistants wear rubber gloves and the same antiseptic precautions are observed as in operating in the abdomen or on the mastoid.

The anesthetic may be local or general. The present case was operated under ether anesthesia but could have been done with cocaine-adrenalin infiltration. The infiltration is done from the nasal vestibule, passing the needles up between the bony and car-



tilaginous nose and the overlying skin, without perforating the skin with the needle.

The object of these operations is to correct the deformity without leaving any scar or disfigurement in the skin. Consequently the incision must be made within the nose, and all the work done subcutaneously leaving the overlying skin of the nose intact. The incision is made within the nose on the left side, in the pyriform fossa, just above the inferior lateral cartilage. With a short sharp knife the incision is begun near the septum and carried laterally as far as necessary, the knife penetrating the mucous membrane and cartilage to the under surface of the skin. The entire skin overlying the left half of the nose is then undermined, extending laterally over the frontal process of the superior maxilla and superior lateral cartilage, and medially over the ridge of the nose; a corresponding incision is then made on the right side and the skin on that side similarly undermined, until it meets the undermined area of the left side. In this way the entire skin covering the nose is elevated from the underlying bony and cartilaginous nose, and forms a sort of a tent under which the rest of the instrumentation is carried out. With ordinary skill this entire procedure can be carried out in a few minutes without perforating the skin. The finger on the outside of the nose follows the knife and acts as a guide. In a like manner the finger outside acts as a guide on all the further instrumentation under the skin tent and by its feel we know just what we are doing.

After the skin was well elevated from the nose, the periosteum was pushed back from the hump and the ridge of the nose with a short periosteal elevator, and, by means of a short saw and a rasp, as much of the hump was removed as was thought advisable leaving the ridge of the nose straight. There remained then the lateral deflection to be dealt with. With the same periosteal elevator the periosteum was pushed from the nasal bone and the nasal process of the superior maxilla. The denuded nasal bone was then sawed through in a line parallel with the ridge of the nose just about at its junction with the nasal process of the superior maxilla. The same process was repeated on the opposite side. The nasal bones were then mobilized as much as possible with the fingers but this proving insufficient to straighten the nose, an Ash forceps, introduced one blade within the incision and the other within the nasal cavity, was made to grasp firmly the



nasal bone. By means of a rotary and an up and down motion of the forceps the nasal bone was fractured from its articulation with the nasal bone on the opposite side, its articulation with the frontal bone and with the frontal process of the maxilla. By this means the bone was thoroughly mobilized. The same process was repeated with the nasal bone of the other side. The Ash forceps was then passed within the nasal cavity, one blade on each side of the septum and the septum fractured as much as necessary to bring the nose to the median line. On account of the previous submucous resection in which most of the deflected bony septum had been removed there was little resistance and very little force was necessary to bring the septum to the median line. The whole nose thus mobilized was moulded into position in the median line.

There was considerable bleeding during the operation but such as it was it was easily controlled by external pressure on the nose, and by the time the operation was completed there was practically no bleeding.

The nose having been brought into proper position, the skin was smoothed down and held in place by means of a saddle of thin copper, patterned previously to suit the shape and size of the nose. This copper saddle was of the kind used by Cohen; indeed the entire technique was very much after the methods which I had seen him employ and the description of the operation follows his. The saddle is covered with adhesive plaster, which not only keeps the copper from coming into direct contact with the nose, but also prevents the edges from cutting into the skin. Within the copper saddle and cut in exactly the same shape and size is a soft piece of cotton flannel backed by a layer of adhesive plaster which acts as a pad for the saddle. An inch and a half strip of adhesive plaster, passing over the saddle and terminating under each ear holds it in place. While the saddle must be snugly fitted and held to the nose, care must be exercised lest the pressure be so great as to interfere with the proper blood supply of the skin.

Before placing the saddle in position both nostrils and vestibules were lightly packed with sterile gauze. Sutures were not used to close the incision.

Cohen mentions the following advantages of the copper saddle over any other means of retention in these subcutaneous operations. "First, owing to its flexibility it can be bent into any desired shape, and the operator is able to make greater or less pressure at



Three Weeks After.



Before Operation.



any required point along the side of the nose. Secondly, by covering the nose in such a splint, the extreme swelling which otherwise must follow is prevented without the least danger of constriction. Thirdly, the skin is held down so evenly that an accumulation of secretion beneath is impossible. Then, also, in working with this soft sheet copper any ordinary pair of scissors may be used."

The saddle was removed and the dressing changed every forty-eight hours, the skin being carefully cleansed with alcohol to prevent maceration.

The local reaction from these operations is sometimes very great, the discoloration being very marked and the swelling of the soft parts and lower lids being sometimes so great as to close the eyes. In my patient the local reaction was comparatively slight and passed off in about a week or ten days. There was no general reaction, no rise of temperature and no vestige of infection. A surprising feature was the almost entire absence of pain after operation, where one would naturally expect considerable pain to follow this rather strenuous manipulation.

#### DISCUSSION.

**Dr. F. W. Parham:** I think the case which Dr. Weil has shown us tonight is a demonstration of the feasibility of doing these corrective operations by intra-nasal method. These cases although not afflicted in a way to endanger life are certainly deserving of any effort we can make to restore them to that condition which will permit their enjoying their social and business relations. Dr. Weil has given us the variety of deformities which justify surgical intervention. These may be broadly classified into those with a hump and those with a depression. I think the operation is a very desirable one and a thoroughly justifiable one. I have not done this special class of work myself within the nose as I believe that it is especially the province of the specialist in this branch of surgery. The operation as performed by Dr. Weil is of the type suggested by Joseph of Berlin. Roe, of Rochester, New York, did much of this work some years ago, but it had not become a popular operation until rejuvenated by the experience of the war. Dr. Tieck wrote last year an article on these intra-nasal deformities based upon 1000 operations performed in the last twelve years, and showed that it is quite a feasible operation. I wish to call Dr. Weil's attention to a later procedure which he did not mention in his paper and may, therefore, not have come to his attention. I refer to the operations as performed by Major H. D. Gilles which he carried out in a large number of cases in Queen's Hospital, Sidcup, England. It seems to me a very simple and a very promising operation. I will hand Dr. Weil a copy of the **New York Medical Journal**, March 16, 1921, in which is an article by Sheehan, of New York, describing the procedure and illustrating it with cuts which make it very clear. It consists in making an incision on each

side of the columna nasi from the tip to the base and then a transverse cut joining the lower ends of these two incisions. The columna is then lifted up and turned up over the nose. The mucous membrane and perichondrium, on each side of the septum are then dissected up for about one-fourth of an inch to make a flap and a separator is slipped in under the tip of the nose under the skin and the necessary dissection made, either for taking out a hump or for slipping in a piece of cartilage which he thinks better adapted for the purpose than bone. The cartilage is taken from at the right of the sternum from the costal cartilages and is slipped under the skin of the nose in these cases, as the procedure is carried out for the purpose of filling out a saddle back depression. Although Sheehan's article is concerned especially with the relief of this depression deformity it is quite applicable also to the correction of hump and other deformities. As to the question of anesthesia, I believe it is quite possible to do this satisfactorily under local analgesia and I believe that this should be the anesthetic of choice in order to obviate the danger of aspiration pneumonia which might follow such procedure under general anesthetic.

**Dr. E. Denegre Martin:** As Dr. Weil very truly said it is within the province of the rhinologist to perform these corrective operations on the nose and I am very glad to know that they are now beginning to enter this field. It should be extended much further for undoubtedly they are better prepared to do this work than the general surgeon. It is a special class of work that I have always enjoyed but most of mine was done prior to the introduction of the newer methods, which of course, are far superior. My work in the modern field has been confined to helping Dr. Lynch in a case which he had about a year ago. I have had two cases of saddle back deformity which were corrected by a very simple method. As these deformities were not great I succeeded in correcting them by introducing a sharp scalpel under the skin in the median line and dissecting the tissues free for some distance on either side. The flaps or loose skin on either side were then advanced until the correction was made and a mattress suture put through from side to side and across the cartilage of the bone to prevent retraction of the skin. In course of time this gave an excellent result. I have also done three complete rhinoplasties with several minor deformities about the nose. I have here the photographs of a case that was interesting. This woman came to my service at the Charity Hospital as a result of a syphilitic destruction of the entire nose. The ulcers had not entirely healed but had so encroached upon the nasal opening that this was almost blocked and she breathed with difficulty. In order to prepare her for a rhinoplasty I enlarged the opening, grafted the edges and healed the ulcer.

Photographs number one and two describe the condition prior to operation. Photographs three and four show the ultimate result, and really succeeded beyond my expectations as this was only the second time that I had attempted the operation. The difficulty in this operation has always been the closing of the nares as the columna was formed by a small strip of tissue extending from the flap. The result was that the lower surface of the flap which formed the columna and the alæ of the nose contracted to such an extent that it was necessary to introduce tubes to prevent blocking and even this was unsatisfactory. Adopting the Indian method by taking the flap from the forehead it is cut pear-shaped and broader than would be necessary by the usual method. The



edges of the skin on either side of the columna are then inverted and held to the skin flap by sutures. This method lines the alæ on either side with skin and drawing the two edges of the flap together forms also an entire skin covering for the columna. In none of the three cases reported was I annoyed by the usual contracture which takes place around the alæ, the inverted skin flap entirely overcoming this difficulty. I must also agree with Dr. Weil, that whereas these operations can be done under local anesthetics, the work is not so satisfactory, especially if other deformities, such as lateral flexion exist, for it is often necessary to introduce the Ash forceps in the nares in order to reduce the deformity. This might be done by a topical application of cocaine but I believe it would add much to the shock, besides the edema resulting from the injection might mislead the operator. The nose can be easily blocked and the operation done with a greater degree of comfort to both the operator and the patient under a general anæsthetic.

**IR F. CHS:** Rhinoplastie surgery is a branch that has been neglected greatly by the rhinologist especially here in the south.

The results of this kind of work are entirely satisfactory and should be an incentive and spur for further endeavors along this line. Contrary to the general impression, patients do not seek corrections of these deformities for vanity, but because they are the subjects of such comment and ridicule from their associates that they become keenly self-conscious and very frequently border on a state of melancholia.

The preliminary submucous resection that Dr. Weil speaks of is not the classical submucous that we usually employ, but is a modified operation, that is the quadrangular cartilage is separated from the vomer and perpendicular plate of the ethmoid and instead of removing it entirely it is pared down and made to fit within its bony confines without bending. At times it becomes necessary to make incisions into the cartilage in order to make it straighten out properly. In cases where the lump is due to the elevation of the lower end of the nasal bones it can be gotten rid of by sawing through the nasal process of the maxilla and then filing down the process with a rasp or file until the proper amount has been removed. The nasal bones are then fractured from their frontal attachments and the elevated end can be easily lowered. This is preferable to sawing for it does not change the normal rotundity and contour of the nose giving it the flattened aspect we sometimes see after removing the humps with a saw.

The question of anesthesia is a debatable one; some men such as Tietze of New York do all cases under local while Cohen of Baltimore has given up local entirely and does all work under general. Personally I believe, for the beginner, the general anæsthetic is far preferable especially where the nasal bone will have to be fractured in order to straighten the deformity.

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## NINETEEN RADICAL SINUS OPERATIONS (KNAPP) DONE UNDER LOCAL ANESTHESIA.\*

By DR. M. P. BOEBINGER.

This monograph is undertaken, not with the idea of bringing out something new, but to report a series of cases done under local anesthesia, and also to report a technic, that of Knapp, which has given the writer his best results, thus far obtained. The author fully realizes that the last word in sinus surgery has not been written, but the radical sinus surgery that can be undertaken and done under local anesthesia, has inspired the author to publish this monograph.

It is not possible to standardize sinus work, as we have done in mastoid and tonsil surgery. A forward step in this direction can be taken by protecting the patient from fear, pain and shock, and the operator from fear of accident that may happen when his technic is trusted to position and sensation of touch in an anatomical field that has its many variations and may be further distorted by the pathological condition. Is it any wonder that the nightmare of rhinology should be sinus surgery? Therefore let me warn you, do not sacrifice thoroughness and safety for speed. If seeing is essential to safety, then we must have our patient in a position that permits of seeing without giving both patient and operator the neck-ache, so often the result of the sitting posture. The writer always has patient placed in the semireclining position.

The blocking of the second division of the fifth nerve anesthetizes the small nerve branches which supply the structures situated between the frontal sinus and nasal cavity.

*Needle employed:*—The needle and extension used for this injection is of special design. (Fig. 1). The extension has sufficient curve to allow the needle to come in contact with the periosteum covering the lateral aspect of the tuberosity of the superior maxillary bone when the hub of the extension is held midway between the occlusal planes of the upper and lower teeth. The needle is made of iridio-platinum, is 40 millimeters long, and 22 gauge.

*Technic of injection:*—The buccal and occlusal surfaces of the upper second and third molars, gum tissue, mucous membrane, and cheek in the region of the upper second and third molar are thoroughly prepared for the needle by applying tincture iodine.

\* Read before the Orleans Parish Medical Society, April 25th, 1921.



1. Showing relationship of needle to upper third molar and lateral portion of tuberosity on skull.
2. Correct position of needle and extension hub prior to injecting solution for blocking the second division.
3. Position of syringe and extension hub for blocking Meckel's ganglion.
4. The medial orbital injection.
5. Area of anesthesia secured by blocking the supraorbital, supratrochlear and infratrochlear nerves.
6. Line of incision.

The syringe should contain 4 c. c. of  $\frac{1}{2}$  of 1% Novocain solution and should be held in the hand pen fashion.

The operator should stand in front of his patient with the pat-

ient assuming the semisupine position. The patient's mouth should be half open to allow the operator to extend the cheek laterally with the first and second fingers to expose the area for the needle. The next step is to puncture the mucous membrane between the gum tissue and inner side of cheek, in other words, the highest point in this region. The needle should enter the mucous tissue above and to the buccal of the apices of the roots of the upper third molar. Great care should be taken not to insert the needle too near the gum tissue for such a procedure would make it impossible to carry the needle in the right direction. In case the needle is started in the gum tissue, it will not follow the periosteum covering the posterior lateral surface of the tuberosity of the superior maxillary bone. After puncturing the tissue in the manner described the needle is advanced upward, inward and slightly backward into the mucous membrane allowing the bevel of the needle to reach the periosteum covering the lateral surface of the tuberosity at the mucous membrane allowing the bevel of the needle to reach the periosteum covering the lateral surface of the tuberosity at an approximate depth of 15 mm. After the needle reaches the periosteum at this depth, the needle is advanced in close contact with the periosteum covering the postero-lateral surface of the tuberosity, approximately 15 mm. making a total depth of 30 mm. The extension and hub should assume a position midway between the occlusal planes of the upper and lower teeth. Force the needle into the mucous membrane as described until approximately three cm. of the needle have disappeared.

The average distance from the puncture point, to the second division of the fifth nerve as it crosses the sphenomaxillary fossa, is (30 mm. or 3 cm.) Great care should be exercised in not allowing the needle to assume a perpendicular course, for if such is the case the needle will not remain in contact with the periosteum covering the tuber maxillare.

If the extension hub is held parallel to the occlusal plane of the upper teeth while the needle is being inserted, the needle point will strike the inferior lateral portion of the greater wing of the sphenoid bone, other lateral portion of the external pterygoid plate. If this has been done, the needle should be withdrawn and the correct technic employed. The route followed by the needle is void of large arteries, veins and nerves, as the needle passes along the periosteum covering the posterior lateral tuberosity of



the superior maxillary bone, it is located anteriorly and laterally to the posterior superior alveolar nerve and artery, as they enter the posterior superior alveolar foramen.

Technic for blocking the sphenopalatine, (Meckel's) ganglion:— A special needle is employed for blocking the ganglion. It is the same as the one employed for blocking the second division of the fifth nerve by the intraoral method, with the exception that the needle is 5 mm. shorter, this making the needle  $3\frac{1}{2}$  cm. in length. The hub is 4 cm. in length, and has a curvature sufficient to allow the needle to pass over the tuberosity in the right direction. The syringe is held in the hand pen fashion, the needle is inserted into the mucous membrane distal to the upper third molar, or, in other words, distal to the tuberosity of the superior maxillary bone. The needle is advanced upward inward and backward to an approximate depth of  $2\frac{1}{2}$  cm. When the solution is injected the point of the needle should be at the sphenopalatine ganglion which is located from 5 to 7 mm. beneath the second division of the fifth nerve and midway between the posterior part of the tuberosity of the superior maxillary bone and the anterior surface of the greater wing of the sphenoid bone. The hub and extension of the needle rests upon the occlusal plane of the upper teeth. The approximate depth of the needle is  $2\frac{1}{2}$  cm. The needle employed being  $3\frac{1}{2}$  cm. in length; 1 cm. will remain exterior to the surface mucosa.

This injection will block the sphenopalatine ganglion and its branches. (Fig. 3).

Median orbital injection for blocking the anterior and posterior ethmoidal nerves. (Peuckart Route).

This deep injection, which is made on the median side of the orbit blocks the ethmoidal nerve branches which supply the anterior and posterior ethmoid cells, the sphenoidal and frontal sinuses and mucous membrane of the cribriform plate of the ethmoid bone. Branches are also distributed to the cartilage and skin of the tip of the nose. Branches also supply the superior and anterior parts of the nasal mucous membrane with sensation, and also supply the superior and middle turbinates.

Before covering the technic, the necessary landmarks will be given.

If a horizontal line (Fig. 4) is drawn along the inner wall of the orbital cavity extending from the optic foramen to the root

of the nose, it will be found that this line passes through the anterior and posterior ethmoidal foramina.

Technic for Median orbital injection:—After treating the skin aseptically, the field is painted with tincture iodine, the nerve blocking needle is now employed, which is 22 gauge, and 60 mm. long.

The puncture point is located on a level with the root of the nose, (Fig. 4) and the needle is in contact with the periosteum covering the inner orbital margin. The needle is forced through the skin, striking the inner orbital margin, holding the needle in both a sagittal and horizontal plane. It is now forced backward along the inner wall of the orbit at the junction of the upper and inner walls, care being taken to keep the point of the needle in contact with the periosteum. The approximate distance between the inner orbital margin and the anterior ethmoidal foramen is 2 cm.

*Structures Anesthetized:*—The blocking of the anterior ethmoidal nerve will anesthetize the mucous membrane lining the anterior and superior parts of the nasal fossa; nasal septum; anterior inferior part of the nose; anterior half of middle meatus and middle turbinate bone; anterior half of the inferior meatus and inferior turbinate bone; anterior lateral part of wall of nasal fossa; anterior ethmoidal cells; and frontal sinus.

*Blocking the posterior ethmoidal nerve:*—After injecting the solution to block the anterior ethmoidal nerve, if it is desired to also block the posterior ethmoidal nerve, the needle is now forced  $1\frac{1}{2}$  cm. farther posteriorly along the medial wall of the orbit. The average distance between the anterior and posterior ethmoidal nerves, as they pass out of their respective foramina, is one and a half ( $1\frac{1}{2}$ ) centimeters; the distance from the inner orbital margin to the anterior ethmoidal nerve is 2 cm; and the distance between the two foramina is approximately  $1\frac{1}{2}$  cm; therefore, the total distance which the needle is inserted to block the posterior ethmoidal nerve is  $3\frac{1}{2}$  cm. Precaution:—Great care should be exercised not to insert the needle too far posteriorly in view of the fact that the optic nerve, as it emerges from the cranial cavity through the optic foramen, is on a direct line with the needle. The average distance between the optic nerve as it enters the orbital cavity through the optic foramen and the inner orbital margin is 4 cm. The needle should not be inserted to a greater depth than 3 cm. so as to make sure that it does not enter the region of the

optic nerve. The posterior ethmoidal foramen is located from  $3\frac{1}{2}$  to 4 cm. from the inner orbital margin, but inasmuch as it might prove a dangerous procedure to insert the needle into the region of the optic nerve as it passes out of the optic foramen, it is therefore advisable to make the maximum depth 3 cm. Even if the injection is made anterior to the posterior ethmoidal foramen, the solution will reach the posterior ethmoidal nerve by infiltration and will produce the desired result. The anesthetic content itself will act upon the optic nerve, but its effects are only transient. Never use adrenalin Chloride solution in this region because the vaso-constriction may produce anemia of the optic nerve.

*Time to wait for Anesthesia:*—Anesthesia is produced in from five to ten minutes in the frontal, ethmoidal, and sphenoidal sinuses. The time required for the solution to thoroughly permeate the epineurium and the second division fibres is from ten to twenty minutes, therefore, always block Meckel's Ganglion and second division fibres first. The time required for anesthesia of the supraorbital, supratrochlear and infratrochlear nerves is three or four minutes.

Kind of solution used:—

Novocain or Apothesine  $\frac{1}{2}$  of 1% solution. Adrenalin Chloride is used only for supraorbital, supratrochlear and infratrochlear nerves and the region of the frontal sinus.

*The combined blocking of the supraorbital, supratrochlear and infratrochlear nerve:*—The face and unshaven eyebrows are cleansed with alcohol and tincture of iodine applied to the field of operation prior to anesthesia.

The supraorbital, supratrochlear and infratrochlear branches are then blocked. The entire anesthesia about the frontal sinus, region of inner canthus and lower portion of nasal bones should be done with a single skin puncture, with a two inch needle, withdrawing the needle just far enough to inject each succeeding area, but not withdrawing it entirely out of the skin; should the operator make multiple punctures he defeats his own end by producing several outlets during anesthesia.

The average distance between the supraorbital and supratrochlear branches at the point of injection is approximately one cm; therefore, if the solution is injected midway between the two points as they pass upward and over the supraorbital margin it will only

have to infiltrate a distance of 5 mm. laterally and medially to block the respective branches. (Fig. 5).

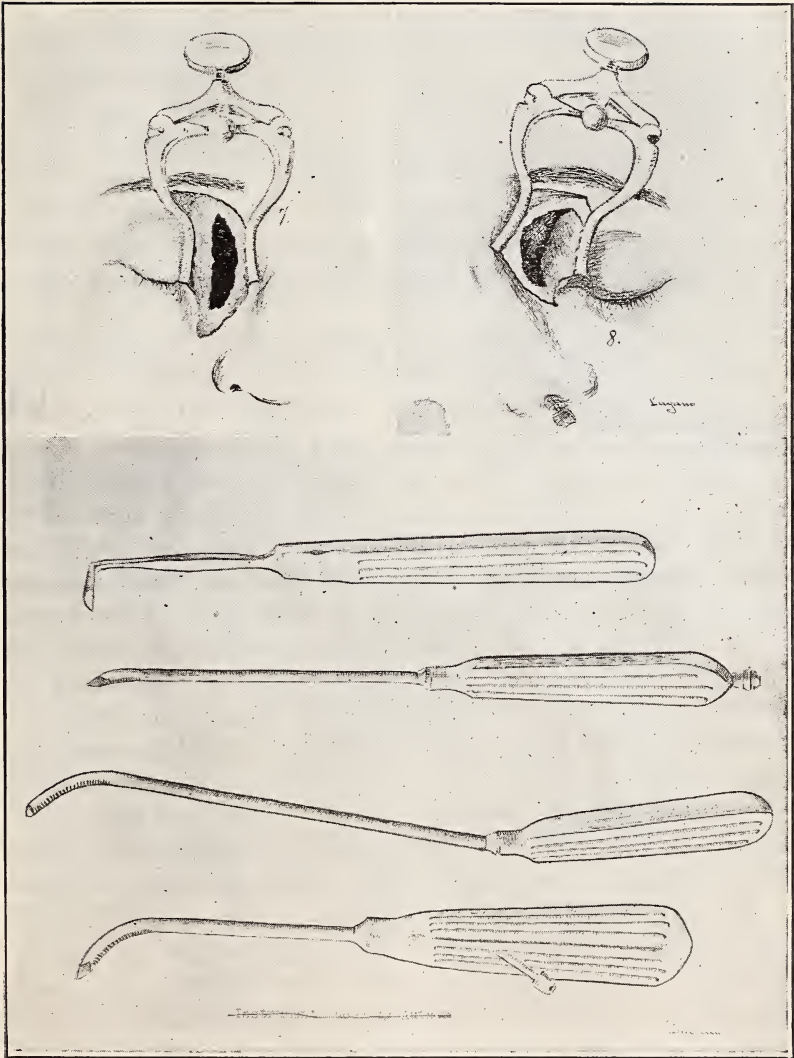
*Incision:*—The operative field and patient are now dressed and eyes protected. A one and one half ( $1\frac{1}{2}$ ) or two (2) inch curved incision is made (Fig. 6) through the unshaven eyebrow, beginning to the medial side of the supraorbital nerve and curved down the side of the nose almost to the inferior end of the nasal bone, it is necessary to avoid injury to the supraorbital nerve which might result in paresthesia or numbness. The incision is deepened to reach the bone. A Jansen mastoid retractor is now placed after elevation of the periosteum and control of hemorrhage the latter is profuse for a few moments but easily controlled with forceps and retractor.

The periosteum is retracted, the author using a very small hoe-shaped elevator (which was made by the Surgical Supply Co. of this City) which has served me most excellently. After the firm adhesion of the periosteum to the orbital margin is separated, the soft parts with the orbital contents and the lachrymal sac are gently detached and free access is given to the roof and the inner wall of the orbit. (Fig. 7). The pulley of the superior oblique is carefully detached from the trochlear fossa. It is important not to disturb the relation between the tendinous ring through which the tendon passes and the periosteum to which it is adherent; the periosteum later becomes attached in its normal position by the healing process and interference with the superior oblique muscle is avoided. This important relation can best be preserved by dislodging the pulley from the trochlear fossa by a blunt periosteotome working from behind forward.

(The author advises the use of the Ballenger submucous elevator).

The entire floor of the frontal sinus is then easily removed with the chisel and hammer, the diseased mucous membrane is curetted and the bony septa in the frontal sinus are carefully eradicated. A portion of the orbital margin can be removed without causing any deformity if the normal curve be preserved. The nasal process of the superior maxillary, the lachrymal bone and the ethmoidal os-planum are then resected, giving broad access to the middle meatus of the nose and to the ethmoidal labyrinth. Work in this region is facilitated by a Jansen retractor. The ethmoidal labyrinth is completely elevated with curette, forceps, etc; remembering that the anterior ethmoidal foramen which is a constant land-





7. Retraction of periosteum, working space with incomplete removal of osseous wall.  
 8. Complete detachment of the orbital contents and removal of floor of frontal sinus, lachrymal bone, os-planum, etc.  
 Below—Instruments used by author.

mark indicates the base of the skull and that as one proceeds back, the ethmoid becomes broader laterally. The sphenoidal sinus is entered if necessary. As broad an opening into the nose as possible is made, in addition to removing all disease to insure proper drainage. (Fig. 8). (The author uses a frontal sinus rasp, of

his own design, to assist in enlarging the opening.)

If the frontal sinus extends unusually high up, as it is apt to, and the upper limit cannot be curretted from below, the cutaneous flap with the eyebrow is forcibly retracted upward, a window is cut in the anterior bony wall similar to the Kuhnt and Killian methods, leaving a broad bony supraorbital margin covered with periosteum; the purpose of this window is not to remove the greatest part of the anterior bony wall but should be only large enough to treat properly the upper parts of the cavity under direct inspection.

Marked subsequent sinking in of the forehead can thus be prevented. (The author has not been obliged to resort to the above method, being able by means of Coakley's curetts to reach all corners and angles of the frontal sinus.) The cutaneous wound is sutured with absorbable ten day chromicized catgut after a single wick of gauze is passed from within the sphenoidal sinus, along through the excavated ethmoidal labyrinth, and floor of frontal sinus, making certain that the gauze does not become caught against the roughened bony edges in the region of the frontal sinus, (this may interfere with subsequent removal of gauze), one end of the wick of gauze is brought down to the vestibule of the nostril, facilitating easy removal after twenty-four hours.

*Dressing:*—The wound edges and neighboring field are carefully cleansed of all blood. The eyes are uncovered and cleansed and a ten (10%) per cent solution of argyrol (freshly prepared) instilled. A large pad of sterile vaseline is placed over the eyelids and a fluff of gauze over this and the operated side, only, bandaged.

The patient occupies a partly upright position in bed. The external wound closes primarily. The nasal cavities are left undisturbed. Diplopia and epiphoria should always be expected; however, the author has not had these complications in nineteen Knapp operations, which can be described as a modified combination of the Jansen and Kuhnt methods.

The complete removal of the ethmoidal structure is also facilitated when the orbit contents can be well retracted. The elements of success in operations of this kind depend upon the use of a proper light (either with mirror or electric forehead reflector and long slender light attached to portable battery and used by writer to explore and search deep field for unopened ethmoid cells after thorough currettment), the control of hemorrhage and a thorough

working knowledge of the anatomy of the sinuses and allied parts. These should, surely, not deter the rhinologist from continuing in the development of this important field.

*Summary:*—The author's cosmetic results are good. No need of incision to extend outward to outer canthus, as in the Killian and Kuhnt operation. The external bandage is removed in about 48 hours and eye left uncovered, small cotton and gauze dressing held on by means of adhesive strips. Absorbable suture material having been used, there is no need for the painful removal of sutures. After removal of nasal pack, if it is found necessary, a dilator is passed into the sinus at frequent intervals and kept up until discharge ceases and convalescence about complete. The author does not irrigate, no nasal douches are permitted and recommend non-interference with wound unless absolutely necessary. No scab formation has been found in all cases and my first case extends back to August 1920.

No pain was felt by patient at any time during operation. No post operative nausea was experienced. No post-nasal packs are used, a matter of increased comfort for the patient and lessening the danger of middle ear disease from detained secretion and irritation from the gauze. Much less hemorrhage than when ether is used. All of my attempts at local anesthesia have been successful, at no time was the author forced to resort to etherization of patient.

Two cases still under treatment. One case gave me a little trouble with localized periostitis, which disappeared by use of ice bag. One case of cavernous sinus thrombosis gave me my only failure, patient died two months after the operation.

The essentials of success in the external operations on the sinuses are, in my experience, a thorough knowledge of the anatomy of the orbit and the accessory cavities, ample drainage into the nose from all the affected cells, or if the mucous membrane be greatly thickened and diseased, its complete removal by Killian or other similar procedure.

The rhinologist must have a thorough working knowledge of the orbit and its contents and of the danger of injury to the eye or its adnexa. The detachment of the pulley is of great importance in order to get at the ethmoidal and deeper structures properly. This feature, and the complete removal of the inferior wall of the frontal sinus, make this method easier than Killian's operation.



When dealing with a double frontal trouble, the inter-frontal septum with the complete removal of floor of the sinuses are done similar to Lathrop technic.

#### DISCUSSION.

**Dr. Martin:** I am inclined to agree with some of the speakers who have preceded me in regard to local analgesia in extensive operations of this kind. Not only from the danger incurred, for I do not believe that any of these operations are without some risk and unless there is some special contra-indication with which I am not acquainted, I think the operation should be done under a general anesthetic. I am free to admit that frequent operations about the nose under local analgesia have made me an arrant coward and whereas there is no pain at the time, the crunching of bone and the knowledge of what is being done, probably more so in my own case as I am more or less familiar with the work, has had such an effect upon me that it has taken me weeks sometimes to recover from the attendant shock. I speak feelingly in this matter and I think that the specialist should take it under consideration. As curious as it may seem, operations about the abdomen do not leave the patient in this condition. I have taken a general anesthetic six times and each time have come out without shock, without nausea, and made a rapid convalescence, but each time that I have had to undergo an operation about the head with a local anesthetic I have been a physical wreck for some days after.

**Dr. A. I. Weil:** I wish to enter a word of protest against the indiscriminate use of local anesthesia and these intricate and more or less dangerous procedures of nerve block, or really not nerve block but ganglion injection, in extensive intranasal operations.

Local anesthesia is admirable in simple nose operations, such as submucous resection, turbinectomies, intranasal antral openings and the like. But when it comes to extensive operations such as that described by the reader I fail to see the advantages and am impressed with the disadvantages and dangers of the method described. There is the danger of infection mentioned by Dr. Dupuy, the danger of damage in the orbit or injury to other parts, especially when this procedure is attempted by one not so expert as the reader, from his paper, appears to be.

On the other hand, ether anesthesia is practically without danger, I believe is more efficacious and undoubtedly leads to a more efficient and thorough operation. There are doubtless certain cases, in which a general anesthesia is contraindicated, where the nerve block is of great assistance, but except in such cases I believe the advocacy of procedures of this kind as a routine measure is to be deprecated.

**Dr. Dupuy:** If we successfully block the second division of the fifth, and infiltrate those branches of the supra-orbital and the trochlear nerves in the skin over the frontal region, we have, I think, sufficient anesthesia to perform such surgery as is called for by the Knapp. I therefore consider the medium orbital injection as unnecessary and as possibly jeopardizing the integrity of the eye-structures.

Let me sound a note of warning, despite the plausible explanations of Dr. Boebinger, relative to the danger of infecting the speno-maxillary fossa when blocking the second division of the fifth. This fossa once infected will lead to our Waterloo. To do this work, experience, technique, and a most scrupulous asepsis are required, hence the warning.



### THE HERO DOCTOR.\*

By HOMER DUPUY, A. M. M. D., New Orleans.

The Soldier-Hero surrounded by the panoply and din of war has ever been the world's darling. The Soldier-Hero is immortalized in the glowing canvas, in chiseled marble, in majestic verse and in rhapsodies of sweet sound. True it is, that the time for heroic action is often amid scenes of terror and turmoil.

In that imperial personification of force and daring we call Napoleon; in the chivalry of that white plumed knight, sans peur et sans reproche, Bayard; in the more commonplace duties of the Dough-boy and the Poilu, there runs unquestionably a strain of the heroic.

The three hundred who defended the pass at Thermopilae and rolled back the tide of Persian advance, the line of steel which held Verdun with the transmitted magic of "Ici ils ne passeront pas", indeed these are to be accounted as heroic achievements.

But the day never dawns, the hour never strikes in which heroism of some sort may not shine forth. Amidst the clash of arms and the boom of cannon, amid the stir of martial music men do deeds of valor. There is however, a valor born of self-denial, self-sacrifice and great heartedness, which makes men and women without thought of glory or fame give themselves completely to others to better serve their fellow creatures. The arena for the display of heroic virtues is not always the noisy and spectacular battlefield. Peace presents countless opportunities for heroism.

See by the squalid chimney-side the sad figure

"Of a woman in unwomanly rags,

Plying her needle and thread,

In poverty, hunger, and dirt,

Stitch! Stitch! Stitch!

And still with a voice of dolorous pitch

She sings the Song of the Shirt.

Surely, there is no blare of trumpet here and yet with all such quiet, genuine heroism!

After all, the valor whose field of action is "grim-visaged war" is not of the highest order. He who serves humanity without thought of expense, health and life itself, is surely the larger and more valiant man.

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\* (Annual address of the president La. State Medical Society, Meeting April 20, 1921).

If utter forgetfulness of self, if to be actuated by high motives in the performance of obscure, and sometimes distasteful duties, if to be above petty calculations and scornful of being scorned, if these constitute the true essence of heroism, then surely have the heroic elements always been at work in the medical profession.

Our calling necessarily makes us plunge with a bold spirit into those rarer dangers which sometimes beset men, and brings us in touch with the most loathsome forms of disease, it brings sounds and sights of suffering with the final vision of violent death. It is no wonder then that we too have our heroes. They lived great and exalted lives, boundless with love for their fellowmen. They toiled and sacrificed that others might live and be happy.

Is it not meet that we pause awhile during the common business of our every day life, and recall the names and deeds of our herodoctors? Let us for our own edification and inspiration pick out some of the bright particular stars from a galaxy of great names—pathfinders they were in the field of medicine—who “left foot-prints on the sands of time.”

Witness the contempt of ease and safety of a Vesalius, the Father of Anatomy. He risked the most terrible dangers in his search for real knowledge. Nothing daunted him. To secure bodies for dissection, unshaken and untterrified, the haunted gibbets and charnel houses, braving the popular fury and the virus of plague.

Witness the persecution of Harvey on account of his epoch-making discovery of the circulation of the blood. Shakespeare with prophetic vision had already made Brutus say to Portia:

“Thou art my true and honorable wife,  
As dear to me as the ruddy drops  
That visit my sad heart.”

But even the medical profession was not yet prepared to accept the great principle of the blood movement. Bitter opposition tried the very soul of Harvey. Deserted by his friends, his practice reduced to a bare living, with gaunt poverty staring him in the face, with undaunted valor, he stuck to the new truth.

Let us recall the fate of Jenner and see the envy, blame, hatred and calumny heaped upon him because he, forsooth, devoted himself to the propaganda of a strange, yet great truth, the potency of vaccination against small-pox. Undismayed by threats and

opposition the heroic in him made him stick his "courage to the sticking place."

Less spectacular, but none the less heroic, is the conduct of a Semelweis of Vienna, who, to reduce the appalling death rate from puerperal fever, took the stand that students doing pathologic work must not attend obstetric cases. The furious persecution which followed drove Semelweis into an insane asylum. He was released from his retreat, however, a well man, but undaunted and defying, returned to the attack, and thus by his valor and constancy was instrumental in the saving of thousands of lives.

Think of the self trust of Ephraim McDowell, who taking his own life and reputation in his own hands dared to perform the first operation for an ovarian cyst under the most adverse environments, by himself and in his own office. Surely, his heroism and his "paths of glory" might have led to the grave, for near by were shot guns ready for action in the event of a fatal result to the patient. The "Woman-Murderer" as he had already been called by the indignant citizens, would himself have been murdered for the courage of his convictions.

Witness the courage and untiring devotion of Pasteur who adhered to his ideal of science, without thought of applause or compensation. He suffered for his discoveries. His good faith questioned, his statistics scorned, his results laughed at, his pension from the French Government about to be revoked, he braved all these and went on with the dull, slow grind of the laboratory. The literature of heroism is richer for such an example of self-immolation.

In the record of self sacrificial acts nothing surpasses the conduct of the brave Lazear who made himself a free and willing subject to prove the mosquito transmission of yellow fever. The tragic sequel—death—was the supreme sacrifice, for he gave his life for his fellowmen. Carroll, during these same experiments, was just as heroic for he barely escaped the same fate.

But just as "many a flower is born to blush unseen", so many of our hero-doctors live a life crammed with great achievements, yet they pass on unknown to fortune and to fame. The world will little note the deeds of our many nameless heroes who, far from the "madding crowd's ignoble strife" pursue the noiseless tenor of their way, in country or in city, in slum or in cottage, always in sympathetic touch with the victims of dire poverty, painful dis-

case and horrible deformity. It is that quiet sort of heroism of a family doctor who, negligent of expense, danger, health and life itself, who braving all kinds of weather, at all hours of the day and night, oftentimes without hope or thought of compensation, answers the call to bring help to human suffering.

In all the great wars and in the devastating plagues that have afflicted mankind, countless doctors have ever shown a glorious contempt for their own safety. During these times which try men's souls, the Doctor is ever present, serene, courageous, unshaken, unterrified—in the discharge of his mission of mercy. No sculptured and emblazoned memorial commemorate the deeds of our wartime and plague-time hero-doctors, even their names have gone down to the tongueless silence of oblivion.

There are many such mute and inglorious hero-doctors, the species, while threatened, is thank God far from being extinct. Hero Doctors an extinct species? Why we have in our own day witnessed the conduct of these physicians who during the last "flu" epidemic paid such a heavy death toll for service to others. Heroes every inch were those who with the first touch of the fatal malady upon their own already weakened, worn out bodies, reckless of their own safety, went cheerfully and courageously to help others with this last, full measure of their devotion. Such heroism feels and never reasons!

Is it not well in this day, at this very hour, when some of us forgetting the high ideals of our calling incline towards commercialism, neglect and selfishness, when some of us are too ready to barter our birth right for a mess of pottage, is it not well, I say, to recall these achievements of our own heroic dead? The record of their noble life should rouse our whole being, should make us catch the finer spirit of their lofty purpose and the inspiration of their high courage. Should make us feel that we are the inheritors of this heroism of the past, and that the age of the heroic and godlike is still here. Such a retrospect should make us feel what a blessed thing it is to live laborious days for others. What a divine thing it is to perish, if need be, in bringing truth, health and happiness to others. The arena in which our hero-doctor acts is not that of aggression or strife, but it is the one of mercy, service and self sacrifice. No stars glitter upon his breast, no bejeweled sword hangs by his side, when he falls, as he often does, in the performance of duty, he falls like "The First



Grenadier of France," DeLatour d'Auvergne. The hero of many battles was killed, Napoleon ordered that his name should be called at every roll-call, and that his next comrade in ranks should answer "Mort sur le champs d'honneur"—"Dead upon the field of honor!"

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**"ANNUAL ORATION"**  
**LOUISIANA STATE MEDICAL SOCIETY.**

By J. ZACH SPEARING, Member Louisiana Bar Association.

Mr. President, Ladies and Gentlemen:—I wish it were given me to adequately express my appreciation of the honor of saying a few words to you this evening, and the pleasure I have in doing so. There is always a compliment implied to an invitation to address any organized body, but this is very greatly increased when the request is from an organization of intelligent and cultured men and women who occupy high places as citizens. I feel particularly gratified in speaking to you of the medical profession because your members like those of my calling come into such intimate intercourse with those whom we serve. It seems to me that you and we get closer to the real human side of the people than do others. True, your relations and ours are not along the same lines, and we come in contact with different human attributes and motives.

The lawyer sees his client in the arena; in the hustle and bustle of business when he is concerned with his material affairs, where frequently selfishness is the chief, and not unusually the only, motive. The Doctor, however, goes into the homes of his patients, and comes in contact with them more in their natural state. He is admitted into the very heart of the family as no other one is. It may be he is attending a patient who is hovering on the brink of eternity and whose living means much to those who fear for the worse; or perhaps a younger life is in the balance and father and mother, and brothers and sisters, feel that he has so much to live for, and is so necessary to their happiness, and has such a bright future he cannot be spared; or again the whole family may be looking forward with the happiest anticipations to the bringing of a new life into the world with a realization of the dangers of such an event. But whether it be in one of the situations I have mentioned, or in others not necessary to refer to, the doctor is the one person who is locked up to as

capable of giving relief and of quieting the fears of those who are so apprehensive. Their emotions, their heartaches, their hopes are exhibited to the doctor as to no other human.

Those occupying that position must be of the highest class of citizenship in the community of which they are a part. And such the healer of human ills always has been, and is, and will be. It matters not whether we look to ancient times when the doctor was among the few learned men of the day; or we consider the Congoes who have implicit faith in their Voodoo doctors; or have in mind our own American Indians who reverence the Medicine Man of the tribe; or think of our present day physicians with all the advantages of our enlightened times, it is always the same, the curer of the sick and the healer of disease, no matter by what name called, is looked upon as separate and apart from the rest of humanity, and he occupies a place in the esteem and affections of the people different from any one else.

As said before, a man such as that is necessarily a good citizen. His own sense of the responsibilities and a realization that he is taken as an example would prompt him to good citizenship. In fact, he cannot reach the height a true physician is entitled to and actually occupies unless he has the attributes of a good citizen.

It might be said the doctor does not usually get out on the hustings; is not often seen in political strife, and does not frequently take an ostentatious part in public affairs. His calling and the line of his work are deterrents in those respects. But they are not the only attributes of good citizenship. One may well accomplish much for the welfare and advancement of the commonwealth or the community by quietly and without show or display benefitting the people. Good citizenship is measured by results attained; not by the means employed.

Of course, the treatment of illness by one means or another is probably co-existent with the human race. The science of medicine as a system of treatment for disease and injuries was in existence for centuries before the Christian Era. The earliest known writers refer to such a system. Much—in fact very great—improvement and advancement have been made in the practice and application of medicine and particularly in surgery. The truth is that in our own time the medical profession has made greater progress than any of the other professions. Little, if any, changes have been made in the practice or application of theology or law. The

fundamental principles are the same, and such differences as have taken place are the result of natural growth.

The medical profession, however, has made great strides in *medica materia* and in surgery. Compare, for instance, present knowledge, learning, treatment and effect of anatomy, bacteriology, hygiene, radiography and a score of other subjects with conditions well within the memory of many of us present to-night and we marvel at the wonderful advantage of the present day generation. This is to be attributed in a very great part, if not entirely, to the ambition, if you will, and the determination of the physician to exert his full power, strength and ability to alleviate suffering in his fellow being and to improve the human race and thus benefit the world and mankind even at great risk and sacrifice to himself.

Voltaire, the noted French writer—whether he was a great one or not depends upon the point of view—very aptly, and, it seems to me, truthfully says of the doctor:

“Nothing is more estimable than a physician who, having studied nature from his youth, knows the proper ties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution, and pays equal attention to the rich and the poor.”

Be it said to the credit of the members of your association that if any do not come within that classification, I do not know them.

Byron, in a very much lighter and more humorous vein depicts the feeling of the average person towards the doctor; he says:

“Physicians mend or end us;  
But though in health we sneer,  
When sick we call them to attend us,  
Without the least propensity to jeer.”

But the sphere of his activities is not confined to the limits indicated in those references. The spirit heretofore adverted to was shown in a marked degree in the World War so recently ended. Partly, from the thirst for knowledge, and, in no small degree, prompted and impelled by the desire and determination to assist and help diseased, wounded and suffering fellow beings the medical profession, probably in greater proportion than any other that went into that conflict and not only made great material sacrifices at home but surrendered comfort, ease and family ties to occupy positions of imminent danger. The knowledge, learning and experience will benefit the human race in an infinitely greater ratio

than any temporary advantage, material or otherwise, which it is possible for the individual physician to enjoy.

If, then, as seems conclusive to me, the physician is a good citizen in every respect it naturally follows that the State owes him the duty of encouragement and protection. He and his profession should be so treated that he will at least have the incentive to continue in the laudable work he has in hand and in the advancement in medical science which is so beneficial to the human race. The profession should be freed from the quack and his existence made impossible.

The individual should be protected in what I assert to be the right to earn a livelihood by his personal learning, ability and exertions without being taxed, in the form of a license or otherwise, for the privilege. It is the rankest injustice and imposition, little if any, short of a crime that you and members of the profession of which I am a member, and others should be taxed for the privilege of earning daily bread by personal exertions. It is hoped that the constituted authorities will soon realize how unjustly is such treatment.

But that has not deterred, and will not prevent, you from doing your full duty, and pursuing your efforts to benefit, help and improve mankind. Those who are actuated by high ideals and lofty motives do not tolerate interference, nor do they permit even injustice to interfere with or impede their progress. It therefore follows that come what may the physician is and always will be in the front rank of good citizenship.

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### CORRESPONDENCE.

University of the Philippines, Department of Pathology  
and Bacteriology.

Manila, P. I., March 28, 1921.

Dr. Charles Chassaignac,

Editor, N. O. Med. & Surg. Journ.

I am led to write to you by two considerations. The first is an urge to express to you my sorrow at the death of Dr. Dyer, whom I have reason to remember very gratefully for having helped me to carry on as a student at Tulane. At the same time I would wish you continued success in your efforts to keep the Journal in the place among American State medical journals that its senior-



ity entitles it to. The second consideration is the invitation that I have just read in the February number to send in news items, etc. Of course, the invitation was to members of the state and parish societies, but as an ex-member I hope that I may be included.

Concerning the meeting of the Far Eastern Association of Tropical Medicine to be held in Batavia, August 6 to 13, it seems worthy of note that this meeting was to have been held in 1915. Since that time the Association has been all but defunct. Though it was conceived by Americans in the Philippines and organized in Manila in 1908, there is at present unfortunately little interest or general knowledge of it here. As in the English and French Oriental territories, the years have seen great changes in local personnel. At present there is no officer of the Association in the Philippines, both of those elected at the Saigon Congress in 1913 having gone to the States, and practically all of the Americans who were active members are now scattered far and wide. Yet not a few of these are doubtless interested in the Association, and if the matter were brought to their attention, some would probably aid in the revival that the Dutch are trying to accomplish by at least renewing their memberships.

Though it is provided that anyone who fails to pay the annual dues for two years shall be dropped, and that to be reinstated he must pay "all his dues", there seems to be no intention to apply that rule to cover this period of inactivity.

Leprosy treatment has naturally interested the health authorities here of late, and a committee appointed by the Director of the Philippine Health Service last year has been testing out the Rogers preparations (gynocardate and morrhuate) in comparison with the Mercado formula that has long been the official treatment here. Subsequently the Hollmann-Dean preparation was included in the tests. The results have been so encouraging that we prepared a plan calling for the appropriation of P600,000 (\$300,000) to apply one or another of the newer methods to all of the 5000 lepers on Culion Island, and at the same time to carry on intensive research on leprosy and its treatment. The bill was finally slated for postponement, but at the last moment we succeeded in getting an appropriation of \$100,000. It is believed that this can be so used and indirectly supplemented as to enable us to make a good start toward the desired end.

You may be interested to learn that the Manila Medical Society,— which is as yet the only component society of the Philippine Islands

Medical Association—decided last year to start a clinical journal for local use, "The Journal of the Philippine Islands Medical Association". A copy of the first issue will be sent you shortly, with an invitation to exchange.

Hoping that this rather lengthy epistle may have something of interest to you, I am

Yours very truly,

(Signed) H. W. WADE.

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## PROCEEDINGS OF THE STAFF OF TOURO INFIRMARY

(HELD AT TOURO ON APRIL 13, 1921.)

DR. J. N. ROUSSEL. Mr. Chairman and Gentlemen, I neglected to bring the history card of the patient along. I am sorry there are no other cases because I would like to have seen them apparently cured at least. In 1918, I saw an abstract in the *American Medical Journal* from a South American Journal on the use of Anthrax vaccine in Leprosy. Dr. Johns sent to the Surgeon-General's office and proceeded to use vaccine on two cases. They both got very much worse after its use and the article in the journal had not stated what happened to them immediately after its use. These patients became so much worse that I recommended that they go home, after which I saw them no more. I saw them last in April 1919 at which time they were very much worse. In December of the last year one came to my office as she had another trouble and when I asked about her other trouble, she stated she had been WELL for a long time; there was nothing the matter and she felt perfectly well. There was no anesthesia. After looking all over, I could find nothing the matter. I then wrote to the other case, which was a tuberculous type, and she told me the same story about having gotten well in June. The first was a maculo-anesthetic type, and I am showing this case because I think it is more interesting than the others. This maculo-anesthetic type had circinated, raised patches; face suffused—red all the time. The whole surface was suffused. In January, I injected twice; pneumonia developed after the second or third injection. After she recovered from pneumonia, another injection was given and the lesions that formerly had been large patches changed to large nodular lesions, typical of erythema nodosum; sharply limited, firm and dense. After another injection, she had other lesions which

looked like a big carbuncle and bullae formed on all of them. In a week or so, they dried up, peeled off and the result is that there is nothing to be seen—nothing but a few stains that you would get from a boil—nothing of the macules.

I want to say that we use the same vaccine that is used in veterinary practice—what the Biological houses call “Liquid Anthrax Vaccine.” We give the same dose as to a horse. I started with a  $\frac{1}{4}$  cc. and went up to one cc. apparently producing very little reaction. The temperature is slightly raised after injection and rapidly disappears. I have been using the vaccine probably oftener than we find it necessary to use—only two or three injections may be necessary; we vaccinate a horse only twice. There are four types of vaccine. (One has been taken off the market because too many animals were killed by its use). I asked Mulford to send full data as to how to manufacture it but they have not yet done so. It is too soon to tell how the other cases on which I used this vaccine are progressing. Somebody suggested this was possibly an “erythema nodosum.” At the time, it probably was an erythema nodosum. She has had Leprosy for years. There is no question as to what the others had. Bacilli were found. Whether the bacillus is paramount we do not know. In more than 50% of the cases the bacillus is not found. (We have made our diagnosis since the time of Moses without the microscope.) Major Denny came to see these cases and they are going to use the vaccine at the Leper’s home.

DR. MATAS: Are there any cases in the Leprosarium in which the bacillus has been found?

DR. ROUSSEL: Yes, nearly all of them. They would not take them without it. As to the transmission of leprosy—it is not inoculable and not transmissible. (73 authentic cases). Leprosy has never been produced from man to man. There is no question in the world but that the bed bug is the only and sole means of transmission of leprosy. It is a house disease. Gregarious bed bugs! They are never carried by natural agencies. There are instances in towns where the head of the family has had leprosy and not one in the family contracted it. In Patterson, in three or four families, the head of the family had leprosy and there was a horde of children but not one contracted it. The head of that family lived in a small outhouse, yet he dined with them and mingled among them but DID NOT SLEEP with them.

DR. PARHAM: How does the bed bug carry it?

DR. ROUSSEL: The bed bug must bite a leper. It is not contagious. I never pay any more attention to it than if it were eczema and I believe the Sisters at the Leper's Home would have it if it were contagious. There is no evidence of where it is contagious. It is a crime against civilization to lock them up.

#### DISCUSSION.

DR. F. M. JOHNS: I remember quite distinctly when Dr. Roussel first became interested in this subject by reason of an article that came from South America in an *A. M. A.* abstract. I procured the original from the Surgeon General's library and had it translated. It was entirely indefinite in dosage and the kind of suspension used, but simply stated that a number of cases had been treated with Anthrax Vaccine. There seemed to be no question in the author's mind but that a large number of patients had been absolutely cured. Dr. Roussel got busy and sent over four or five patients to me for laboratory examination. I found several with organisms. The worst cases were placed on treatment. While it is pretty hard to place any biologic connection between the curé by the anti-bodies formed by anthrax bacilli in the leprosy lesions, the results that he has here in actual cases are simply astounding.

The method of making this vaccine is that of attenuation, simply by growing the organism upon certain culture media upon which the organism loses its power to grow within animal tissue. Typhoid bacilli, for instance, grown on culture media for many years, lose their ability to grow or reproduce in living tissue. Bouillon cultures of typhoid by the billions were fed by some college professor to his family. The vaccines given by Dr. Roussel are simply living cultures of anthrax bacilli so attenuated that they do not kill test animals. I believe only the worst cases should be given these live cultures first, as in actual veterinary practice a horse occasionally succumbs to an injection.

DR. LANFORD: I examined smears from the last case and found organisms, morphologically *B. leprae* occurring in a form in which we recognized considerable degenerative changes and which were without doubt leprosy bacilli.

DR. F. W. PARHAM: I would like to ask Dr. Roussel about the incubation period. I thought the period was very long. There might be difficulty in determining whether or not it is contagious on this account.



DR. J. N. ROUSSEL: I would like to answer Dr. Parham's question. I do not think the question of incubation of leprosy has ever been settled. Some patients say they have only seen these lesions during the last few months. Then they will say "O yes, last year," and finally, I find they have had it four or five years. Whether it is long or short nobody knows; until we can find the mode of transmission, we will never know. I think we have to find some other way of treating leprosy besides Chaulmugra Oil. It was used in the United States about 120 years and I understand the general impression in India is that it has been used for 4000 years. I think it ought to be relegated to absolute obscurity, and it is a crime to use the ethyl esters. It is most painful. I won't use it on anybody anymore. Whether Anthrax vaccine will do what I think it will do is the question. This patient shown is probably not entirely well. The other patients took over six months. They have been apparently well—clinically—over two years. Leprosy is not often spontaneously cured.

One case which Dr. Van Wart sent me was of a nerve type; absolute anesthesia. After the first injection given her, I told her to report to me exactly what happened. She said she had a chill, little fever which did not last long. Said "my hands have been on fire ever since. "I have had my hands in water and they are on fire." Something evidently awakened them. She burned her hands on the stove. The nerves are apparently not destroyed. I have seven cases now under treatment. I will be able to tell you more later.

DR. MATAS: I cannot resist saying something after the important statement made by Dr. Roussel. Any statement regarding the cure of leprosy which has yielded such extraordinary results in his hands, cannot be passed by in silence or treated with indifference in this community. The history of leprosy in Louisiana is too well known to be insisted upon. The people of Louisiana are more deeply concerned in the control of leprosy than the citizens of any other state in the Union, and any mode of treatment or cure that promises more certain results than those already in vogue, must command the immediate attention of the profession and the public. Without attempting to discuss the relations of the new cure of leprosy by injections of anthrax vaccines which appear, thus far to be based upon purely empiric experience and not upon any known bacteriologic or scientific foundation, we are faced with

the mere fact that a certain number of clinically well authenticated and unmistakable cases of leprosy have been symptomatically relieved, in an extraordinarily short time, of their most characteristic lesions and leprosy manifestations. While the bacteriologic proof of the specificity of these lesions by the demonstration of the Hansen bacillus is lacking in most of them, I would not hesitate to accept the diagnosis of leprosy as correct on the simple clinical evidence when this was recognized as unmistakable by an expert so familiar with the disease, as Dr. Roussel. Granting the correctness of the diagnosis, the remarkable improvement, practically amounting to a symptomatic cure of these patients (all advanced cases), following promptly after the injection of the anthrax vaccines, is in itself a fact which commands attention. This is the more interesting as no other treatment was given these patients apart from the vaccines. Unfortunately the number of patients thus treated is limited to three and of these, only two have been able to appear before us tonight. Judging by the clinical histories, these two patients show extraordinary improvement since the anthrax injections were given. It cannot be said, however, after examining them, that in either case, they are absolutely free from the disease as there are still relics or leprosy stigmata which remain and have not been completely effaced. The local improvement and general relief is, however, phenomenal, and, from this point of view alone Dr. Roussel is entitled to every encouragement and to our hearty congratulations. If similar results could be obtained and demonstrated in a large number of well authenticated cases,—bacteriologically and clinically leprosy,—and it was proven that such results invariably followed the anthrax vaccine inoculations, and furthermore, that the cure should prove permanent, i. e. that the patients remained free from all the manifestations of the disease for a long period of observation, say two or three years, we would be fully justified in claiming for this treatment one of the greatest achievements of our time,—the momentous problem of the eradication of leprosy would be solved.

But the history of leprosy warns us to be cautious in committing ourselves to hasty generalizations based upon a few isolated or limited number of observations which, no matter how striking, suggestive, or encouraging, have not been subjected to the rigid tests of prolonged scientific scrutiny in the centers of the infection where large numbers of the victims of the disease are congregated.

and kept under surveillance. It is only in such centers of segregation that critical collective investigations can be carried out during long periods of time. Such conditions exist in the Leprosarium or Lepers Home in this state. The facts presented so earnestly and impressively by Dr. Roussel are quite sufficient to justify the Government Authorities in charge of the leper colony, in making a serious effort to determine the value of the new remedy. We know that great improvements in the treatment of leprosy have been claimed for various agents and yet in the end they have proved disappointing. More recently, the ancient therapeutic claims of Chaulmoogra oil have been revived for its derivatives, the ethyl esters of the fatty\* acids of this oil, but I doubt that any of the cases reported cured by the Chaulmoogra esters could show a greater or as quick an improvement in the same period of time as that shown by Dr. Roussel's cases treated with anthrax vaccines. Medical history in general and the history of leprosy in particular, has made us wary of over enthusiasm; only time with a large added experience can safeguard us against premature and fallacious conclusions.

In the meantime, let us hope that Dr. Roussel will continue his interesting observations and that the results of his further experience may confirm the success thus far obtained.

In reporting his success with anthrax vaccines, Dr. Roussel has brought the old debated question of the *contagiousness* or *non-contagiousness of leprosy*. This, of course, is of great and crucial importance from the sanitary and hygienic point of view, as it is upon this that the segregation of lepers is based. If the curability of leprosy by any specific remedy could be absolutely demonstrated the problem of contagion or infection would sink to a secondary plane and would be shown of a great measure of its importance, as the eradication of the disease would be certain. As the matter stands, the segregation of lepers must remain a thoroughly justified obligation on the part of the sanitary authorities of all countries. Practicing all my life in this community, where the opportunities for observation have not been lacking, especially in the earlier years of my practice, when lepers were not subjected to sanitary surveillance or restrictions, I have been impressed with the facts that have come under my observation. These

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\* See Dr. J. T. McDonald's report on the treatment of leprosy with Dean's derivatives of Chaulmoogra oil. Apparent cure in 78 cases at Kalihi Hospital, Honolulu, H. I. *Jul. Am. Zs'n.* Nov. 27, 1920.

have impressed me, as every one else who is familiar with Leprosy and the literature of the disease, with the immunity enjoyed by the vast majority of individuals who come in contact with it and are exposed to the effects of this infection.

In 1878 and 1879, when I was an intern at the Charity Hospital, there was a ward devoted exclusively to Lepers and there were always 10 to 15 beds occupied by leprous patients in all forms and stages of the disease. It was a very common thing for the interns to visit this ward to examine these patients and to study the disease. I was especially interested, and frequented the ward a great deal. I took copious notes and made minute examinations as I intended to write my graduation thesis on the subject; but as I became better acquainted with the subject, I found the literature so vast that I gave up the attempt as it was too big a task for my limited time and capacity. Even more than the interns, the sisters and ward attendants mixed up with the patients constantly as there were no particular restrictions imposed upon any one except that the Lepers were all housed in this ward. To my knowledge, none of the sisters, interns, or other attendants ever contracted the disease, except an old Italian priest, Father Boglioli, who for years had been the hospital chaplain. He had given much of his time and attention to these patients, in fact he practically lived with them. He contracted Leprosy and he was the only one who developed the disease in the hospital. He lived a number of years and finally died of a leprous laryngitis with the most typical and generalized manifestations of the mixed tuberculous and anesthetic types of leprosy. In the incipiency, and while the diagnosis was in doubt, he continued to minister to the other patients of the hospital without restriction. I knew him well, and he was a fine, self-sacrificing and noble character, who was faithful to his duties and his ministry to the last. He was a true martyr and deserves all the praise that was given to that world known and now historic character, Father Damien, who sacrificed his life to the lepers at Molokai. Father Boglioli was a man in apparent good and robust health before he entered the service of the Charity Hospital. There can be no doubt that he contracted the disease through contact with the lepers at the Hospital. His mode of life, food, and surroundings were those of the people in his environment, and yet he alone contracted leprosy and died from its effects. Now why should he have been selected as the victim of



the disease among the hundreds who were exposed to the same infection and enjoyed a complete immunity from its effects?

Evidently there was something in his physical make up that differed from his associates and fellow workers; something, an unknown x— that predisposed him to the disease.

Dr. Roussel has suggested, as others have, that there is an intermediary host, which acts as the transmitting agent, like the mosquito in malaria and yellow fever, or the louse in typhus; but why should an infected bed bug or louse single out one out of a hundred of individuals who with infinitely more reasons were exposed at the hospital to the bite of similarly infected parasites? Evidently this is an explanation that does not explain.

I remember another case, that of another leper, the son of an Italian fruit vendor, who kept a shop on Common Street (near Tulane Ave.) which provided fruit daily to hundreds of medical students at the lunch hour, when we travelled at noon, the familiar road from the Hospital to the old University. I, and others, had noticed the extraordinary appearance of the boy's face for some years before we realized that he was a leper and it was only when he was mutilated by the loss of his fingers and by other hideous marks of the disease that he retired from this shop and finally died in the same house, surrounded by his family and large gathering of friends. Yet his parents, brothers, sisters, and other immediate relatives who were housed in the same narrow and crowded quarters never gave evidence of leprosy, nor did I ever hear of any case of leprosy which had developed among the medical students who frequently bought fruit in his shop. This is one of the hundred of instances of a similar character which can be quoted from the immense literature of leprosy. All that we learn from this is that the vast majority of civilized mankind are immune to the disease; that only some and relatively few, are predisposed to its effects. It is in this immunity that we of the modern period of history differ from our European ancestors of the middle ages. With the return of the crusaders from the East, Europe was overrun by leprosy and lazarettos for the lepers were founded and established everywhere, which, at that time, had assumed the character of an epidemic disease. In the course of centuries, the population of Europe seems to have become relatively immune and leprosy has remained active only in a few isolated zones or areas where it still prevails—as in Brittany, in Sweden and Norway.

Ireland, Southern Spain (Grenada) Portugal, Greece, and Turkey—where in certain spots—the inhabitants still furnish pastures where the Hansen bacillus may thrive. Epidemiologists teach us that the great plagues of humanity have their periods of activity when they attain the maximum of virulence and their periods of decline ending in virtual extinction when the masses have been immunized to the effects of the virus by constant filtration through successive generations of individuals who have survived its effects. This is the case of leprosy as it was in Europe in the middle ages. Only the primitive races or aboriginal people who first come in contact with the disease are now ravaged and suffer as the older peoples suffered in the earlier periods of their history. The same may be said of measles, scarlatina, small pox, tuberculosis, etc. which decimate and attack with fearful mortality the native populations in lands which have been long isolated from contact with the European races and civilization.

The immunizing or at least attenuating effects of age upon the virulence of the great contagious diseases is notably illustrated by syphilis. We do not now recognize the syphilis of today as the syphilis which invaded Europe at the close of the middle ages as it stalked all over Europe after the Siege of Naples coincidentally with the discovery of America in 1492. The treponema then found its chief pabulum in the externals of the body and in the peripheral organs, in the skin, bones, mucous membranes, where it spent its fury, causing the hideous eruptions, ulcers, and deformities which have given syphilis its most legendary terrors. Then the disease ran a comparatively short course, melting the tissues into pus with so much rapidity that it came to an end, with death, long before the central organ of the nervous system were reached. Now we scarcely see these monstrous medieval types of external syphilis. The skin and underlying tissue and the skeleton have been in a measure, immunized and a new type of syphilis—the neural and visceral type—the 20th century syphilis,—with all its occult and more deadly manifestations ( paresis, tabes, aortic disease, aneurism) has come to take the place of the syphilis of the 14th century.

How are we to account for these modifications in type, their attenuations, and the relative exhaustion of these, at one time, most aggressive and widely diffused contagions?

We can only account for these changes by the gradual, but progressive immunization of the surviving races especially those that have

survived the hereditary contagion—like syphilis and leprosy and even tuberculosis. Someone has said that syphilization travels hand in hand with civilization, and this is no doubt true, in a great measure, of leprosy. The transmissibility of leprosy and its contagiousness in the sense of communicability, cannot be denied. But it differs from other contagia in the fact that the vast majority of civilized mankind has been immunized to its effects, and it is only here and there in isolated spots over the globe, that the bacillus of Hansen finds a soil that is fit for its growth. Thousands may be exposed to the seed, may carry it in their persons, but few, very few indeed, are fit culture media for its growth. Therefore, as long as we cannot differentiate the immune from the non-immunized segregation is in order.

DR. GESSNER: Has leprosy not been attributed to eating fish?

DR. MATAS: Yes: this was Jonathan Hutchinson's theory, because leprosy has persisted in seafaring and sea girt countries,—but this has been long refuted,—for instance, Grenada, in Spain, where leprosy has existed since the moorish invasion, is not a seafaring or fish eating country.

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DR. L. R. DEBUYS: I am disappointed that I have not the other case to make the group of four which I had expected to present tonight. The other case showed *craniotabes* one of the symptoms of *ricketts*, the bones of the head being almost as thin as paper. The case did not come. It is difficult to get children to these clinical meetings, first, because we send out from the ward our cases as soon as they are over their acute condition, and second, because it is not easy to have them brought here at night at the hour of these meetings.

**Case 2.** This boy shows the interesting symptom—**Hutchinson teeth**. We need say nothing more about that as you know what it means. I take this opportunity to show you one of these cases presenting this late manifestation of **congenital lues**, simply as a reminder. An interesting thing in connection with this case is that there are several children in the family and our records show that we treated all the other members in infancy and early life, but this is the only one who was not brought to us. He shows this interesting feature while none of the other members of the family do. Another feature in this case is that he is now in an inactive state. His Wassermann is negative. He does, however, show a very marked Luetin reaction, so he shows this other interesting observation.

**Case 3.** Another case I wish to present tonight is a particularly typical one and I am going to select the term of "Mongolism" instead of one of its synonyms in speaking of her. This case has been under our observation for quite a long period. She was first brought to us in July, 1917 when she was one year and ten months old because of her inability to walk. In the history it was stated that the mother had gone past term, the pregnancy being one of eleven months. Had always been a mouth breather. When first seen she had no teeth. Examination showed the child to have a typical mongolian expression, a brachycephalic head, eyes close together and slanting, epicanthus present, a heart murmur, rather typically shaped hands, the little finger hardly reaching the middle of the ring finger and being curved inward. There was no umbilical hernia. The diagnosis at that time was "Mongolism" (Mongolian idiocy.) Her Wassermann was negative as was also her Von Pirquet. She was late in talking and could only say indistinctly "mama" "papa." While she was chubby and fat, there was no suspicion of her being a cretin. Radiologically her bony development was negative. She is the fifth child in the family. It is noteworthy that at the time of her birth her mother was forty years old. These cases are frequently spoken of as "reproductive exhaustion products," and are to be found as the last child in a large family. There is a poor and defective development of the brain in this condition. There is a predisposition in these cases to bronchial and acute pulmonary disturbances; she had had several attacks of pneumonias. As you can see, she is very late in talking and much below par mentally.

**Case 4** is noteworthy as it presented a feature that we should always bear in mind. The child is three years old, a native of Mexico. He was admitted into my service on December 30th, 1920. Family history was negative. There is really nothing of interest in his past history. The history of the present illness is as follows:

On the 28th of December, he ate some salmon, hard boiled egg and pie for supper about 5 P. M. The next day he had temperature of 100  $\frac{3}{5}$  degrees F. (rectal), was fretful and apparently had pain in his right abdomen as he held his body continually to one side. A physician was called and gave Castor Oil and suggested that the child had appendicitis. Two enemias were given with fairly good results but the baby continued in great pain, was fretful and cried a great deal.

Apparently suffering from pain in right abdomen. There was no nausea and no vomiting. Maximum temperature on that day was 103 degrees F. Physical examination showed patient to be a fairly well developed and well nourished male child, cheeks flushed, apparently depressed, skin hot and dry. Respiration 32 and not labored, temperature 103  $\frac{4}{5}$  degrees F. (rectal). Mouth negative, pharynx very red, ears negative, pupils negative, abdomen slightly distended. No rigidity. Apparent tenderness on deep palpation in lower right quadrant. I was unable to confirm this. Liver was negative. There was nothing of note in the nervous system. I could find nothing in the thorax. The patient, however, did have a respiratory grunt, jerky respiration and movement of the alii nasae though there had not been much cough. The examination of the urine showed nothing abnormal. The blood examination showed a total white count of 35,850 with an 82% neutrophile count. The patient was sent to the ward with a tentative diagnosis of pneumonia. This was later confirmed by the X-ray. We found a small patch in the right lung. Daily observations were made with the X-ray. We



saw the patch grow larger and finally disappear. Dr. Samuel will describe the plates showing the evolution of the pneumonia. I regret that we did not take a blood culture on the first night as the culture made later was found to be negative. Dr. Lanford later made some serologic observations upon the blood which he will tell you about.

The clinical observations in this case are not very unusual in pneumonia in infancy. The typical physical chest findings not being shown until the consolidation extends from the surface to the hilum. There is a definite lesson to learn in connection with the case; namely, that in a sick child with a jerky, rapid respiration, respiratory grunt, and movement of the ali nasae and cough, it should be required of us to *exclude* rather than to prove the existence of pneumonia.

#### DISCUSSION.

DR. LANFORD: I would like to say something about the blood work done in the case. Serum was obtained from this case about ten days after the patient was free of fever and we tested this serum for specific immune substances using known types of pneumococcus. We were able to rule out by means of the precipitin test and agglutination test, types one, two and three and several varieties of the type four pneumococcus, so that our conclusions—rather our results—were negative as far as the known strains of pneumococci were concerned. This, however, does not prove that the case was not one of pneumonia due to the pneumococcus because we know that the pneumococcus of the type four is composed of large numbers of varieties and we would have to have a great number of different strains to test this serum against.

From the clinical findings, and X-ray pictures, it certainly appears to be one of pneumonia and despite the negative serum reactions, I am inclined to believe that the diagnosis of pneumonia is correct.

DR. DEBUYS: Just another word. We believe all lobar pneumonias to be due to the pneumococcus. Here we have undoubtedly a lobar pneumonia though we have been unable to place the blame on any one particular strain of the pneumococcus. It is possible as Dr. Lanford has said that it may be due to one of the strains in group IV. It is unfortunate that we did not make a blood culture the first night the patient was seen as it may then have been positive.

(To be continued.)

PROCEEDINGS  
LOUISIANA STATE MEDICAL SOCIETY

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REPORT OF THE HOUSE OF DELEGATES TO THE  
GENERAL ASSEMBLY, APRIL 21st, 1921.

The House of Delegates begs to report that four meetings of the House were held, April 19th, two; April 20th, one; and April 21st, one, during which all business of the society was transacted. The minutes of the various meetings of the Executive Committee held during the year, were approved.

The report of the President, Dr. Homer Dupuy, was given. The following three recommendations contained in his report were unanimously adopted:

1. The abolition of physicians license tax. In this regard, a special committee appointed by the Chair, at the recommendation of the House, drew up a set of resolutions which were sent to Hon. M. H. Carver, Chairman of Taxation Committee, Constitutional Convention, in regard to same.

2. That it be the sense of the State Medical Society that whenever two or more component societies of the State Society see fit to join together for scientific purposes, that this union be fostered by the Council of the State Society, and that the Council take steps towards that end.

3. That our scientific program be arranged under two separate sections, Medicine and Surgery, and that the papers be arranged accordingly without any separation of special sections, thus interspersing contributions on special subjects with other papers. This does not do away with the allotment of papers under different sections, but only refers to arrangement of same in our Official Program.

The Secretary-Treasurer made his annual report. The financial status of the society showed: Balance in General Fund, \$3,490.71; Medical Defense Fund, \$5,301.02.

Two special recommendations made by the Secretary-Treasurer were:

1. That the Post Graduate work, instituted by the Louisiana State Medical Society at this meeting, be continued and rearranged to suit respective requirements **in the future.**

2. That an annual meeting be proposed of the various secre-

taries. This last recommendation was adopted, and the Post Graduate subject referred to a committee.

The Chairman of the Council, Dr. Geo. S. Bel, submitted his report. Likewise, the Councillors from all eight congressional districts. These reports were all accepted as read with the following recommendations :

1. In the report of the 1st Congressional District, Dr. Paul Gelpi recommended that members of the State Medical Society in St. Bernard Parish be invited to become members of the Orleans Parish Medical Society, which was adopted.

2. Likewise, in the report of the Councillor of the 2nd Congressional District, Dr. Geo. S. Bel, that members of the Parish of Jefferson be invited to become members of the Orleans Parish Medical Society, was adopted.

The following Committees submitted their reports which were ordered received and filed :

1. Committee on Scientific Work—Dr. P. T. Talbot, Chairman.
2. Committee on Public Health—Dr. T. A. Roy, Chairman.
3. Committee on Medical Defense—Dr. P. T. Talbot, Chairman.
4. Committee on Health and Public Instructions—Dr. R. B. Wallace, Chairman.
5. Committee on Cancer Research—Dr. Wm. Harris, Chairman.
6. Committee on Publicity—Dr. P. T. Talbot, Chairman.
7. Committee on Medical Education—Dr. L. R. DeBuys, Chairman.
8. Committee on Hospital Standardization—Dr. R. O. Simmons, Chairman.
9. Committee on Health Problems and Education—Dr. A. A. Herold, Chairman.
10. Committee on Drug Addiction—Dr. W. H. Seemann, Chairman.

The Committee on Memorial submitted a very interesting report covering deaths of members of the society for the past two years. They recommended, that in the future, owing to the difficulty of securing proper list of deaths occurring in our State membership, that the Councillor from the respective districts be required to send these direct to the Secretary-Treasurer, whenever occurring, and further recommended and adopted that, by this plan, the Committee on Memorial be abolished.

The Committee on Hospitals, Dr. J. W. Newman, Chairman, rendered a very interesting and painstaking report recommending formation of Hospital Diagnostic Unit to be fostered by the La. State Medical Society and sent out into the rural districts as needs might arise. This report created considerable discussion and after being referred to a special committee, who made a report,

the final disposition of the original report of Committee on Hospitals was referred to our Council for action.

The Committee on Budget and Finance, H. W. E. Walther, Chairman, commented favorably on the financial status of our Society and our manner of bookkeeping instituted by the office of the Secretary-Treasurer. They recommended that one-half of the balance in savings account of Medical Defense Fund be used to purchase bonds of similar nature as now held by this fund, which was adopted.

Committee on Industrial and Economic Relations to Medicine, Dr. I. Cohn, Chairman, offered a very instructive and highly interesting report containing some recommendations pertaining to workmen's Compensation Act. This was referred to special committee whose recommendations were reported back to House and adopted as follows:

"That Dr. Cohn and his Committee deserve credit and commendation for the interesting and enthusiastic manner in this difficult work. That the principle of fee schedule we agree unanimously, be fundamentally wrong, and that proper steps by the Society to obtain elimination of this fee schedule as hereby recommended are urged."

The recommendation of Dr. Cohn that doctors signing fee schedule be ineligible to membership in the Louisiana State Medical Society, we cannot approve. With regard to recommendations of Health and Insurance the question not being before any Legislative body we know of, we refer to Committee on Legislation to take proper steps as occasion arises.

The report of the Louisiana State Board of Medical Examiners was read by Dr. E. L. Leckert, giving minute statement of receipts and expenditures of State Board, along with detailed statement of progress and anticipated work of the Board in the future.

Charters were granted to Lafourche Valley Medical Society and Miss. Valley Medical Society, upon application duly executed and signed by Secretary-Treasurer and other officers of respective societies.

The following Parish Societies were reported organized during the past year: Beauregard, Natchitoches, St. Martin, Tangipahoa, Iberia, St. James, St. Mary, Vermilion.

Our delegates to the A. M. A. were instructed to favor establishment of Section on Anesthesia if deemed feasible at the approaching meeting of the House of Delegates of the A. M. A., June, 1921.

Dr. H. W. E. Walther, Chairman, Section Genito-Urinary and



Rectal Diseases, presented a request that this section be entitled "Section on Urology," which was granted. The other recommendation made by him, that his section be allowed three papers instead of two was not approved.

Upon report and recommendation of the Chairman of the Committee on Drug Addiction, the report was received and Committee discharged.

It was brought to the attention of the House of Delegates by Dr. Paul Gelpi that information has been received to the effect that a bureau was being established in New Orleans and Louisiana with the idea of preventing experimental work on animals (Anti-vivisectionists). This subject was discussed, referred to the Council, who recommended that the whole subject matter be referred to a special committee for investigation and report to the first meeting of the Executive Committee.

Upon motion made by Dr. Eustis, it was ordered that, if in the judgment of the Publication Committee, any paper required to be illustrated in connection with the scientific program, the expenses of same will be paid by the society.

A very extensive report containing account of Committee on A. M. A. meeting, 1920, was submitted by Dr. A. E. Fossier.

A report of the committee appointed to consider the recommendations of the Secretary-Treasurer with reference to Post Graduate work was submitted with recommendations that arrangements be left to the discretion of the Committee on Arrangements for future meetings.

The Committee on Resolutions submitted report containing resolutions which were adopted.

Dr. P. B. McCutchon, a former Secretary-Treasurer of the La. State Medical Society presented the minutes of the State Medical Society covering a period from 1878 up to 1887, which was accepted by the House with thanks.

Upon unanimous vote of the House, by-laws were suspended and Dr. B. W. Smith, Franklin, was unanimously elected Chairman of the House for next year.

The following officers were nominated and duly elected by the House:

Dr. J. E. Knighton, Shreveport, President; Dr. W. H. Harris, New Orleans, 1st Vice-President; Dr. R. Bruce Wallace, Alexandria, 2nd Vice-President; Dr. T. A. Roy, Mansura, 3rd Vice-President.

**COUNCILLORS:**

Dr. F. T. Gouaux, Lockport, 3rd Cong. Dist.; Dr. L. J. Williams, Baton Rouge, 6th Cong. Dist.; Dr. E. M. Ellis, Crowley, 7th Cong. Dist.; Dr. S. J. Couvillon, Moreauville, 8th Cong. Dist.

**Ali re-elected for a Period of Two Years.**

Dr. S. C. Barrow, Shreveport, was elected to fill the un-expired term of Dr. J. E. Knighton, 4th Congressional District.

**COMMITTEES:**

**Scientific Work**—Dr. P. T. Talbot, Chairman; A. Henriques, S. M. Blackshear.

**Public Policy and Legislation**—Dr. Homer Dupuy, W. H. Block, with President and Secretary-Treasurer of Society.

**Publication**—Dr. P. T. Talbot, Chairman; Amedee Granger, C. J. Gremillion, Alexandria.

**Budget and Finance**—Dr. Robt. Bernhard, Chairman; Drs. M. J. Lyons, M. P. Boebinger and J. O. Weilbaeher, New Orleans.

**Medical Education**—Dr. B. W. Smith, Franklin, 3 yrs., L. R. DeBuys, Chairman, for 1 yr. and C. W. Allen, New Orleans, 2 yrs.

**Medical Defense**—Dr. R. O. Simmons, 3 yrs.; Dr. Allan Eustis, period of 1 yr.; Dr. J. C. Willis, Shreveport, 2 yrs.

**Health and Public Instruction** was combined with Committee on Public Health containing four members: H. Fleming, E. L. Leckert, T. A. Roy and R. O. Simmons.

**Cancer Research** was changed to that of Committee on Cancer Control. It consists of the following: Dr. W. H. Harris, New Orleans, Chairman; Dr. J. C. Willis, Shreveport, and Dr. A. Henriques, New Orleans.

**Hospitals and Committee on Hospital Standardization** was combined to be known as Committee on Hospitals. Consists of the following five members: Dr. I. I. Lemann, New Orleans, Chairman; Dr. J. W. Newman, New Orleans; Dr. J. A. Lanford, New Orleans; Dr. L. J. Menville, New Orleans and Dr. G. J. Hirsch, Monroe.

**Industrial and Economic Relations to Medicine**—Dr. I. Cohn, Chairman; Dr. A. E. Fossier, Dr. W. H. Block, Dr. Geo. Roeling, New Orleans.

Dr. W. H. Seemann was elected as delegate to the A. M. A. for a period of 2 yrs. Dr. P. Gelpi, alternate, 2 yrs. Dr. L. R. DeBuys, delegate for 1 yr. Dr. T. A. Roy, alternate for 1 yr.

The next place of meeting was decided for Alexandria.

The following resolutions were adopted:

Whereas the ladies, the local medical profession, Mayor of the City of New Orleans, the Chairman and Committee of Local Arrangements, Loyola Post Graduate School of Medicine, Tulane University, Tulane Post Graduate School of Medicine, Presbyterian Hospital, and local press have left nothing undone to make the present meeting of the Louisiana State Medical Society both pleasant and profitable;

Be it resolved; that the thanks be extended upon behalf of our Society to all concerned for their gracious and untiring efforts to make our stay in their midst most pleasant and profitable.

Whereas the officers and clerical force of the Society have been untiring and successful in their efforts to maintain the strength and dignity of our Society during the past year,

Be it resolved that the thanks of the Society be extended to our

past officers and the office force for their unflinching devotion to our beloved Society.

Whereas it has been generally commented that the business of this meeting has been transacted with such punctuality and smoothness that the fact that there was a machinery of operation was scarcely apparent. Be it resolved that thanks and appreciation be extended to our Secretary-Treasurer, Dr. P. T. Talbot and his assistants whose foresight and efficiency rendered the above possible.

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## NEWS AND COMMENT.

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**THE BOSTON SESSION OF THE AMERICAN MEDICAL ASSOCIATION.** The meeting of the American Medical Association will take place this year in Boston, June 6 to 10. Reduced rates are to be put in effect by railroads under the Central and the Western Passenger Associations and in some instances round trip rates will be made. These rates, however, apply mostly to states in the Northern, Western and Eastern parts of the country, while from points in the South little or no attention seems to have been paid by the railroads in making the trip attractive by reducing the fares to points of connection with other lines. Members who desire to take advantage of special railroad fares should send to the Secretary, Dr. A. R. Craig, No. 535 North Dearborn Street, Chicago, for identification certificates.

**SOUTHERN PUBLIC HEALTH LABORATORY ASSOCIATION.** Directors and sub-directors of both municipal and state laboratories will be eligible to membership in the Southern Public Health Laboratory Association established for the purpose of securing uniformity of methods and procedure among the Public Health Laboratories of the Southern States. The first meeting was held in Atlanta on March 16 and the following officers were elected: President, Dr. Clarence A. Shore, Raleigh, N. C. and Secretary, Mr. T. F. Sellers, Atlanta.

**CHANGE IN BOARD OF GOVERNORS OF THE N. A. R. S.** At a special meeting of the National Anesthesia Research Society, at Columbus, Ohio, in April, Mr. Stephen Morris resigned as President and member of the Board of Governors and Dr. E. I. McKesson, of Toledo, was elected to fill his place. Dr. R. L. Clements, of Philadelphia, was elected to the Board of Governors to fill the unexpired term of Mr. Morris. Dr. W. L. Jones, of Columbus,

was chosen to fill the as yet unfilled position of 2nd vice-president. Dr. W. D. B. McNeider, of the University of North Carolina, Dr. B. H. Schlomovitz, of Milwaukee, and Dr. Wm. Webster, of the University of Winnepeg, were elected to the Research Committee.

**MEETING OF THE ST. TAMMANY PARISH MEDICAL SOCIETY.** The regular annual meeting of the St. Tammany Parish Medical Society this year took the form of a dinner, served at Gabe's Tavern on April 14. After the transaction of business quite a number spoke. A toast was tendered by Dr. A. C. Maylie to Dr. N. M. Hebert on his fiftieth wedding anniversary. The other members present joined in the words of congratulation and Dr. W. J. Durel also paid a tribute to Dr. Hebert, who in response, gave a humorous picture of the physician in the pioneer days of the practice of medicine. The following resolution was adopted: "Whereas the Almighty God in His wisdom has seen fit to allow the celebration of the Golden Anniversary of Dr. and Mrs. N. M. Hebert on the 50th year of their married life, The St. Tammany Parish Medical Society extends to Dr. and Mrs. Hebert hearty congratulations and felicitations and expresses the sincere wish that the family will have for many more years the guidance and wisdom of these beloved parents. Dr. Hebert as a doctor, as a citizen and father of family is a living example to the rank and file of the medical profession. Therefore, the Society in executive session moves that a copy of these resolutions be printed in the minutes, a copy sent to the *NEW ORLEANS MEDICAL AND SURGICAL JOURNAL* and published in the *St. Tammany Farmer*.

**ROENTGEN RAYS HAS ANOTHER MARTYR.** William Ironside Bruce, of the Charing Cross Hospital, London, died, after illness of only two months, at the early age of 45 years, his death being occasioned by a severe form of aplastic anemia caused by the penetrating rays of the roentgen tube. The death of Dr. Bruce has brought the appointment of a committee of physicians, physiologists and roentgenologists to investigate the conditions which tend to bring about the death of the workers in the field of roentgenology and radium.

**MEETING OF THE ARKANSAS MEDICAL SOCIETY.** The annual meeting of the Arkansas Medical Society took place at Hot Springs, Arkansas, on May 3, 4 and 5. It was noted that at the close of



1920 the total membership of the Society was 1140, the largest in the history of the society. All meetings were held in the Arlington Hotel and the Entertainment Committee proved adequate in supplying various forms of amusement and the sessions were interesting and instructive. Altogether, the meeting was very satisfactory.

**LEXINGTON CLINIC.** An association consisting of Drs. David Barrow, Woolfolk Barrow, W. O. Bullock, Ernest B. Bradley, W. T. Briggs, F. H. Clarke, C. C. Garr, J. T. McClymonds and W. S. Wyatt, has been formed under the name of the Lexington Clinic for the purpose of the practice of group medicine. The Clinic is provided with a modern Clinical Laboratory and equipment for X-ray diagnosis and treatment. An adequate supply of radium is available for therapeutic use. The medical profession is extended a cordial invitation to visit the Clinic.

**MEETING OF THE STATE MEDICAL ASSOCIATION OF TEXAS.** This meeting was held on May 10, 11 and 12, at Dallas, Texas. The opening exercises and all general sessions, as well as the scientific exhibit were conducted in the City Temple, and the registration office was situated in the Oriental Hotel. A reception committee representing the Women's Auxiliary of the Dallas County Medical Society were on duty at the principal hotels and at the office of the registration for the purpose of receiving visiting women. An excellent program was followed throughout the meeting and many social features lent added interest to the occasion, which included alumni banquets, and memorial services for the members who had died during the past year were conducted. Other meetings which were held jointly were the Texas Railway Surgical and Hygienical Association and the Texas Roentgen Ray Society, to which the members of the State Association were invited.

**REGULATION OF MEDICAL DISTRIBUTION OF BEER AND WINE.** On April 7 the regulations for the prescribing of beer and wine to be enforced tentatively, were made public for the practicing physician and these are as drastic as could be imposed under the terms of the Palmer ruling. Summarizing these regulations we note that a limit is placed on beer to be prescribed for any one patient during any one month so that only  $4 \frac{1}{7}$  gallons, or two glasses a day may be allowed. Only one physician may prescribe for any one patient at the time. Only physicians

may issue certificates for beer and wine and only druggists may fill them, both being held to strict accountancy. Registered pharmacists cannot be employed by wholesale brewers or druggists to fill prescriptions and a physician may not fill a prescription for his own use. Only a duly qualified brewer or wine maker is allowed to manufacture these beverages for medicinal use, and only this on the property where the manufacture is specified. It must be noted, however, that these regulations are only tentative.

CO-ORDINATION OF NATIONAL HEALTH AGENCIES. On May 1 the National Health Council opened new offices in the Penn Terminal Building, using two floors. In this building will also be located the offices of the American Social Hygiene Association, the National Committee for Mental Hygiene, the National Organization for Public Health Nursing, co-operating with the American Nurses' Association and the League for Nursing Education, and the National Tuberculosis Association, all on the fifteenth floor, while on the sixteenth floor will be located the offices of the American Public Health Association, the Bureau of Social Hygiene, the Child Health Organization of America, and, probably, the liaison office of the United States Public Health Service, the National Health Council, with the Common Service Committee; the Maternity Center Association, the New York Diet Kitchen Association, the New York Community Service, and the American Society for the Control of Cancer.

AMERICAN FIELD SERVICE FELLOWSHIP FOR FRENCH UNIVERSITIES. The Society for American Field Service Fellowships for French Universities, among other awards, granted the Fellowship in Medicine to Percival Bailey, a graduate of the School of Medicine of the Northwestern University. Applications for the 1922-23 Fellowships should reach the Secretary, Dr. I. L. Kendel, at 522 Fifth Avenue, New York City, not later than January 1, 1922.

AMERICAN HOSPITAL IN PARIS. The Board of Directors of the American Hospital in Paris has purchased a new building site near the present hospital. A new 100 bed hospital building will be erected after plans drawn by C. C. Knight an American architect. The building fund of 3,750,000 francs is to be increased to 7,000,000 francs and an endowment fund of 4,500,000 will be provided.

**INFLUENZA HITS RHINE ARMY.** The Second Battalion of the Eighth Infantry has been quarantined by medical authorities since the development of forty-five cases of epidemic influenza which broke out among the soldiers belonging to the United States occupational army stationed near Coblenz.

**TEXAS STATE BOARD OF MEDICAL EXAMINERS.** The semi-annual meeting of the Texas State Board of Medical Examiners will be held on June 21, 22 and 23 in the Hall of the House of Representatives, Capitol Building, at Austin, Texas, instead of at the Medical College at Galveston, as previously announced. Candidates for the examination should write to Dr. T. J. Crane, Secretary, addressing him at No. 918-19 Dallas County State Bank Building, at Dallas, Texas, for blanks and other information.

**MISSISSIPPI STATE MEDICAL ASSOCIATION.** The annual meeting of the Mississippi State Medical Association was held at Laurel on May 10 and 11. An interesting program was well carried out. Good management and enthusiasm, which usually characterize the meetings of this Association, were especially noticeable. The following physicians from New Orleans were in attendance: R. C. Lynch, J. T. Halsey, R. A. Strong and Elizabeth Bass.

**FOURTH DISTRICT MEDICAL SOCIETY MEETING.** The regular semi-annual meeting of the Fourth District Medical Society of Louisiana was held at Shreveport on April 5. The meeting of the Shreveport Medical Society was held at the same time and both Societies went on record as favoring State aid in establishing a Tuberculosis Hospital. A number of interesting papers were read and a Symposium on Abdominal Pain conducted at the evening session, followed by demonstration of X-ray pictures, a business session, refreshments and adjournment. A symposium on Uterine Hemorrhage will be held on June 7 by the Shreveport Medical Society.

**HONOR CONFERRED ON DR. LAPLACE.** Dr. Ernest La Place, formerly of New Orleans, has been decorated as an officer in the French Legion of Honor by Rene Viviani, special envoy of France. The ceremony took place on April 19 in New York. In 1902 the "Palms Académiques" were conferred upon Dr. LaPlace by the French government in recognition of his valuable medical researches. Later, in 1906, he was made a chevalier in the Legion of Honor.

RESOLUTION ON THE DEATH OF DR. WILLIAM KOHLMAN. A resolution on the death of Dr. William Kohlman was adopted by the Loyola Post-Graduate School of Medicine, as follows:

“Whereas, in the death of Dr. Kohlman, the Medical Profession has suffered an irreparable loss, for his was a life filled with many activities, noble endeavors, and lofty purposes. He lived intensely for the good and happiness of others. His mission of mercy and help to the indigent sick was of such a character and so generously given that his death must prove a genuine sorrow and a real calamity to many of the suffering poor, and

“Whereas, His passing away deprives the Board of Directors and the Faculty of the Loyola Post-Graduate School of Medicine of a wise counsellor and an efficient teacher. He became identified with the School in the very beginning of its career and was, in fact, one of its enthusiastic organizers. He ever remained loyal to its purposes and devoted to its interests, therefore,

“BE IT RESOLVED, That we, who deeply appreciate the sterling qualities of mind and heart of our deceased colleague, and we who realize the scope of his valuable services to our School, in a spirit of reverence, gratitude, and love, we do hereby order these resolutions to be inscribed in our Minutes, thus indulging the fond hope that we can help perpetuate the name and deeds of the one so worthy of such remembrance, and

“BE IT FURTHER RESOLVED, That we tender to his wife, and to his family, our heartfelt sympathy in this, their greatest bereavement, and that we order a copy of these resolutions be sent to the family by the Secretary of the Board.”

BEQUEST. By the will of the late Dr. Wm. Kohlman, a bequest of \$2,500 is made to the New Orleans Hospital and Dispensary for Women and Children.

PERSONALS: Dr. C. C. Bass attended the meeting of the Georgia State Medical Society on May 5, and lectured before the Johns Hopkins School of Medicine, in the series of DeLamar lectures, on May 9, and then went to Atlantic City to attend the meeting of the Association of American Physicians on the 10th and 11th of May.

Dr. Chaille Jamison, Assistant Professor of Clinical Medicine of the School of Medicine of Tulane University, has been appointed on the staff of the City Board of Health and will be attached to the bacteriological laboratories.

Dr. Herbert Winsdor Wade, formerly of New Orleans, has been appointed President of the Manila Medical Society. Dr. Wade is a Tulane graduate of 1913.

Dr. J. A. Henderson after four years' service at the naval hospital Charleston, S. C., has received his discharge and returned to New Orleans to resume practice.



REMOVALS: Dr. A. L. Peters, from McNary, La., to 165 Elk Place, New Orleans.

Dr. J. A. Crawford, from Sulphur, to Longville, La.

Dr. F. E. Lindahl, from Hammond, La., to Royal, Illinois.

Dr. C. C. Thompson, from Delhi to Shreveport, La.

Dr. W. M. Jackson, from Otis to Joyce, La.

DIED: On May 11, Dr. Harry T. Igne, of Mobile, Alabama, aged 60 years, and a resident of Mobile for the past forty years.

Dr. Roland F. Thomas, on May 9, aged 38 years, at New Orleans, La.

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## BOOK REVIEWS AND NOTICES

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*All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

**A Synopsis of Medicine**, by Henry Letherby Tidy, M. A., M. D., M. Ch. (Oxon.), F. R. C. P. (Lond.). William Wood and Company, New York, 1921.

This book aims at providing a synopsis of such principles of medicine as are of importance at the present time. Into its relatively small bulk the author has compressed an extraordinary amount of information, which is in the main correct and up to date. Whether a work of this character will find a large field of usefulness appears doubtful to the reviewer. Perhaps, as the author hopes, it may prove of assistance to those who have to review rapidly their knowledge of medicine in general or of some disease in particular. For such purposes it seems admirably suitable.

J. T. H.

**The Diagnosis and Treatment of Heart Disease: Practical Points for Students and Practitioners**, by E. M. Brockbank, M. D. (Vict.), F. R. C. P. Paul H. Hoeber, N. Y.

In this little work, small enough to slip into one's pocket, the author has succeeded in putting simply, clearly, and concisely the elements of cardiac anatomy, physiology, and pathology as well as those of diagnosis and treatment. It cannot be expected that in a work of this size (less than 160 small pages) anything beyond the elements can be discussed, but this discussion is clear and up to date and is savored by the salt of common sense and wide clinical experience. Well chosen cuts, diagrams, and curves serve to illustrate and elucidate the text. Like most modern cardiologists Dr. Brockbank has escaped from the influence of the school which over emphasized the significance of cardiac murmurs. Those who have not the time (or the will?) to read the larger works on this subject, this booklet will prove a fairly acceptable substitute.

J. T. H.

**Principles of Biochemistry**, by T. Brailsford Robertson, Phd., D. Sc. Lea and Febiger, Philadelphia, 1920.

In the preface the statement is made that "while the design of the author has been primarily to write a text-book for medical students and students intending to specialize in biochemistry and physiology, the attempt has also been made to compile a work which will be of service to the agricultural student, the student of general biology, or the industrial chemist who is engaged in handling biological products."

In accordance with this rather ambitious plan the author has, in addition to the usual matter contained in text-books of biochemistry, included much material which is usually to be found in works on physiology. Chapters dealing with such subjects as artificial fertilization, old age, and senescence, the fading of memory traces, sleep, etc. being included.

As is to be expected from the author's extensive investigations in these fields, the application of physical chemistry to biochemical phenomena, and the physiology of the ductless glands is treated in considerable detail, with the result that the sections dealing with such fundamental subjects as urine, blood and milk have been cut to the minimum.

It is to be questioned whether this work is of the type best suited for the routine instruction of the average American medical student, although its value to the teacher or student of biochemistry or physiology, or to the physician seeking information of recent advances in these sciences, is unquestionable.

W. DENIS.

**Physiological Chemistry**, by Albert P. Matthews, Ph. D. William Wood and Co., New York, 1920.

The fact that this work has been reprinted five times, and has passed through three editions since its appearance in 1915, gives evidence of its popularity. The text has been thoroughly revised, the chapter on vitamins in particular, having been practically rewritten. As in the case of the earlier editions the last 260 pages are given over to a description of laboratory methods of interest to the physiological or pathological chemist. In this section extensive additions have been made, particularly in the portion dealing with blood analysis; the popular "System of Blood Analysis" of Folin and Wu; the newer micro-methods for the determination of the inorganic constituents of blood, and for the study of acidosis by means of blood examinations are described in considerable detail. The section on urine analysis has also been enriched by the description of some of the newer technique, although here the revision has not been so thorough as in other sections, as much dead wood still remains in the form of descriptions of methods of urine analysis long obsolete.

This volume will prove, as in the case of the earlier editions, a valuable reference book for the physician desiring information on newer methods of laboratory examination or on the so-called "theoretical" aspect of the physiological chemistry.

W. DENIS.

**The Practical Medicine Series**, under the general editorial charge of Charles L. Mix, A. M., M. D., Vol. VIII: **Eye, Ear, Nose and Throat**. Edited by Casey Wood, M. D., Albert H. Andrews, M. D., and George E. Schamburg. Series of 1920. The Year Book, Chicago, Illinois.

The handy volumes of the Practical Medicine Series long ago firmly

established themselves in the esteem and affection of the profession. The light volumes which compose each issue cover all subjects pertaining to medical science, so that no notable advance is overlooked. While these volumes are of primary interest to the general practitioner, still they are so arranged that any specialist may select the volume that appeals to him, without buying the entire series.

The present volume (Ear, Nose and Throat) is the product of men to whom we have grown accustomed to look for light and leading. The present book is up to the high standard that we have found in their contributions to these series for years past. An analysis of the contents is unnecessary, for it would have to embrace all the progress in 1920 that is worth knowing in the branches discussed. McSHANE.

**The Practical Medicine Series.** Comprising eight volumes on the year's progress in medicine and surgery. Under the general editorial charge of Charles L. Mix, A. M., M. D. Volume II, General Surgery. Edited by Albert J. Ochsner, M. D., F. R. M. S., LL. D., F. A. C. S., Major M. R. C., U. S. Army. The Year Book Publishers, Chicago, 1920.

This volume opens with an interesting chapter on anesthesia and analgesia in which all essential points in the year's progress in both local, spinal and general anesthesia are discussed.

A wealth of interesting material is spread out over the pages of this volume which maintains the high standard established by this publication. The world's literature is fairly thoroughly reviewed except from the central empires which are not available, and as is to be expected it contains much of war surgery selected from the best of the year's contributions. Civil surgery has, however, not been neglected and is well represented in many excellent selections.

The volume is well indexed and contains many excellent illustrations. ALLEN.

**The Surgical Clinics of Chicago, Oct., 1920.** Vol. 4, No. 5. W. B. Saunders Co., Philadelphia, 1920.

It is difficult to pick up any number of these clinics and not find papers of more than ordinary interest; this however would naturally be expected from the high standing of the contributors.

The October number is no exception to the rule and presents articles by the following:

Drs. E. Wylls, Edmund Andrews, Charles Louis Mix, David C. Strauss, Arthur Dean Bevan, Golder L. McWorther, Richard L. Tiven, Kellogg Speed, Carl Beck, Alfred A. Strauss, Albert J. Ochsner, Daniel N. Eisendrath, Frederick G. Dyas, Allen B. Kanavel, Edward Louis Moorhead, Geo. E. Shambaugh, Edward Lyman Cornell and Roy L. Moodie. ALLEN.

**The Surgical Clinics of Chicago, Vol. 4, No. 6, Index number.** W. B. Saunders Co., Philadelphia, 1920.

This number opens with an excellent article by Dr. Bevan on "Ex-trophy of the Bladder" and is followed by other cases in the clinic. Dr. Kellogg Speed's case of "Tendon Transplantation for Wrist Drop," which is freely illustrated, will be found quite instructive.

There are many other splendid articles notable among them, "The after Treatment of Infections of the Hand" by Allen B. Kanavel, author of the excellent book on this subject. ALLEN.



**MORTUARY REPORT OF NEW ORLEANS.**

Computed from the Monthly Report of the Board of Health of the City of  
New Orleans, for April, 1921.

CAUSE.	White.	Colored.	Total.
Typhoid fever	2		2
Intermittent Fever (Malarial Cachexia)			
Smallpox			
Measles	3		3
Scarlet Fever	1		1
Whooping Cough	3		3
Diphtheria and Croup			
Influenza	3	1	4
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	6	31	67
Cancer	29	11	5
Rheumatism and Gout		1	1
Diabetes	7		7
Alcoholism	1		1
Encephalitis and Meningitis	2	2	4
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	23	7	4
Paralysis	2	1	3
Convulsions of Infancy	1		1
Other Diseases of Infancy	10	8	18
Tetanus	1	1	2
Other Nervous Diseases	5		5
Heart Diseases	54	34	88
Bronchitis			
Pneumonia and Broncho-Pneumonia	21	15	16
Other Respiratory Diseases	1	2	3
Ulcer of Stomach			
Other Diseases of the Stomach		2	2
Diarrhea, Dysentery and Enteritis	20	13	33
Hernia, Intestinal Obstruction	5	2	7
Cirrhosis of Liver	6		6
Other Diseases of the Liver	2	2	4
Simple Peritonitis			
Appendicitis	6	5	11
Bright's Disease	19	12	
Other Genito-Urinary Diseases	9	3	12
Puerperal Diseases	4	5	9
Senile Debility	2		2
Suicide	6		6
Injuries	15	9	24
All Other Causes	28	22	50
<b>TOTAL</b>	<b>348</b>	<b>189</b>	<b>537</b>

Still-born Children—White, 30; colored, 19; total, 49.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 14.40; colored, 20.62; total, 16.11. Non-residents excluded, 14.43.

**METEOROLOGIC SUMMARY (U. S. Weather Bureau).**

Mean atmospheric pressure	30.05
Mean temperature	68.
Total precipitation	4.87 inches
Prevailing direction of wind, southeast.	













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