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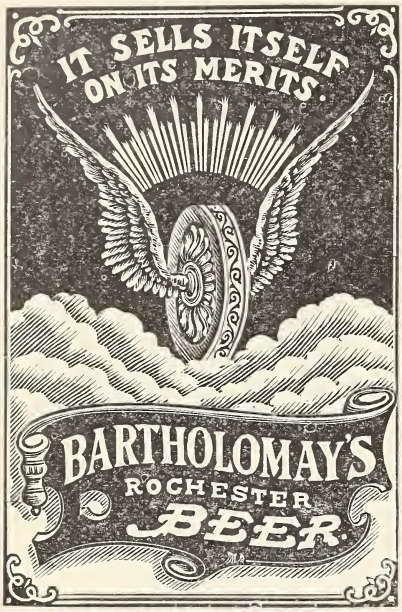

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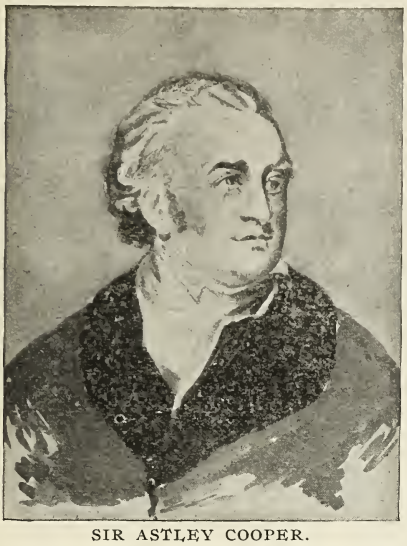

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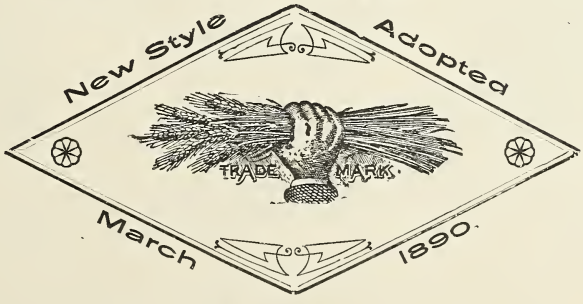

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MARYLAND
MEDICAL JOURNAL

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Original Articles.

CEREBRAL SYPHILIS.

By George J. Preston, M. D.,
Baltimore.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, HELD AT HAGERSTOWN, MARYLAND, NOVEMBER 10 AND 11, 1896.

Without going into the pathology of cerebral syphilis it will be remembered that the disease generally attacks the structures formed from the mesoderm.

Thus the tissues invaded are :

1. The skull.
2. The meninges.
3. The blood vessels.

It is quite probable, as Gowers points out, that syphilitic lesions occupying, as they occasionally do, deeper parts of the cerebrum, have followed the blood vessels down, or can be traced up to the pia mater. Syphilitic disease of the skull causing caries or exostosis may be widespread or localized and the same thing may be said of syphilitic meningitis, which may extend over large areas of the base or convexity of the brain, or confine itself to a very limited space, constituting the characteristic focal meningitis. The blood vessels may be affected generally or as the result of local disease.

Syphilitic disease of the cortex presents, according to Darier, three distinct forms :

1. Diffuse gummatous infiltrations.
2. Localized patches of encephalitis.
3. Patches of sclerosis.

From the foregoing résumé of the anatomical lesions produced by syphilis it is evident that the symptomatology of cerebral syphilis must present great variety. Thus we may have symptoms of general arterial involvement eventuating in thrombosis or hemorrhage, differing in few particulars from arteriosclerosis from other causes. Again, the meningitis and encephalitis met with are not always to be distinguished from like conditions of very different etiology. Finally, we may often have a perfect picture of brain tumor without suspecting the nature of the lesion.

As we know, the history of the primary lesion is notoriously uncertain, so that we are often compelled to decide by the character of the symptoms.

Moreover, syphilis of the nervous system may follow the primary lesion after a very long interval. Most frequently perhaps two or three years elapse between the occurrence of the initial lesion and the involvement of the nervous system, but this interval may be almost indefinitely prolonged.

It is not uncommon to see the nervous system invaded ten, fifteen or twenty years after the occurrence of the chancre, and the average individual is not to be expected to remember accurately the details of a sore on his penis which dates back twenty years.

Syphilitic disease of the bones of the skull fall within the province of surgery

and the pressure symptoms which are sometimes present are easy to recognize. Syphilitic meningitis presents certain features which are somewhat characteristic. In the first place, the process is nearly chronic, the symptoms coming on gradually. Then this variety of meningitis is for the most part localized.

When a considerable extent of the meningeal surface, either basal or cortical, is involved, one side is apt to be much more affected than the other, or there appear certain foci of intensity. With the meningitis there is very often associated more or less encephalitis. When the syphilitic growth, starting, as has been said, from the meninges, invades the substance of the cerebral hemispheres, we have a picture of brain tumor.

Of the general symptoms the one that usually attracts attention first is the headache. This may be localized or diffuse, basal or cortical, very continuous, with exacerbations which usually occur at night. Not infrequently this headache is associated with insomnia. If the basal meninges are involved, which is the case in a large proportion of all cases, then we have paralyses of the cranial nerves.

The most frequent paralysis is that of the third pair, giving ptosis and disturbances of motion of the eyeball. The fourth or sixth pairs of nerves are not as frequently affected as the third. Of course it must be remembered that paralysis may be due to the involvement of the nucleus or nerve trunk. While the onset and course of nuclear and peripheral paralyses present marked differences it is sometimes difficult to make a clear diagnosis between them.

In general the gradual appearance and slow course of the paralysis together with the fact that an involvement of part of a nerve or rather of certain branches only, with other bulbar symptoms, point to disease of the medulla. Involvement of the optic nerve may give rise to some form of hemianopsia. The double optic neuritis which is so common in basal meningitis is a symptom of great diagnostic value.

The facial nerve may be involved and occasionally the other cranial nerves, as in Case VI, in which there was transient disturbance of the tenth pair. Hemiplegia from syphilitic arteritis is common and resembles ordinary apoplexy except that it is often of very much slower onset without loss of consciousness. It is also possible to have a hemiplegia due to involvement of the crus. Sometimes, as in Case V, the involvement of the medulla gives rise to polyuria or even melliturıa.

When the vertical meninges or the subjacent cortex is affected it is very common to see epileptiform seizures. These attacks do not differ materially from epilepsy from other causes except that it has seemed to me that they are far more apt to be followed by transient paralyses and distinct mental symptoms. Again, syphilis of the vertex induces many mental symptoms which are not connected with convulsive seizure. The insomnia, which has been alluded to, and the still more frequent condition of somnolency, are very generally met with. In some cases, particularly when the meningitis runs a rather acute course, there may be present marked excitement with wild delirium, followed by somnolency or coma. This may make its appearance early, or may follow later in the course of a general mental degeneration, as is shown in Case II.

Perhaps the most common form of mental disturbance is that of depression with mental hebetude and general change of disposition. This condition is not so much one of depression as of apathy. The patient is not able or at least not inclined to any effort. Sometimes they are irritable, but more often in my experience apathetic and expressionless. These cases simulate very closely general paresis of the insane, and probably the mistake is not infrequently made clinically. As a rule, there is wanting the distinct delusion of grandeur, and the paralysis, aphasia or other evidence of focal disease clears up the diagnosis.

As has been said, it sometimes happens that the syphilitic inflammation

follows the meninges or the blood vessels down deep in the ganglia or white matter of the cerebral hemispheres, in which case the only symptoms are those of intracranial tumor. Most frequently, however, even in cases of this variety there are lesions elsewhere, either meningeal or focal.

In general it may be said that the characteristic symptoms of cerebral syphilis are the irregular course of the disease, not confining itself to any system of fibers, attacking now one part of the brain, now another, more frequently multiple than single; the transient nature of the paralyses; the frequent involvement of the eye muscles; the intense headache; the somnolency and the peculiar manifestations, now a state of excitement, now of depression or apathy. Contrasted with any of the other forms of brain lesion the multiformity of the symptoms and their irregular course cannot fail to impress the observer. The following cases present some points of interest.

Case I. Seen in consultation with Dr. H. B. Thomas. The patient, a man of 36, had always been healthy, and with no neuropathic heredity. In 1893 he had a chancre for which he was treated. In July, 1895, he had dragging of the right leg, with loss of power of the right arm, and with this was associated a distinct motor aphasia. These symptoms disappeared under antisyphilitic treatment. I first saw the patient in January of this year. At that time his condition was as follows: His speech was fairly good, there being a little tendency to slurring in his articulation, but no aphasia.

His memory was almost entirely gone for recent events and greatly impaired for things that had happened years ago. For example he could give only a very vague account of his syphilitic trouble of three years previous, while he could not remember the name of his law partner, nor the street upon which he lived. On being asked what he had for breakfast he laughed in a silly way and seemed rather ashamed of the fact that he could not remember. He was unable to recall the names of his relatives, or to tell any events happening during the past few days.

There is decided loss of power in the limbs and the reflexes were exaggerated. Examination of the eyes showed no muscular paralyses. Ophthalmic examination showed great congestion of the disc in the left eye. There is absolute homonomous hemianopsia right. He complains of severe and continuous pain on the left side of his head. Sexual desire was greatly increased. He was put on large doses of iodide of potassium with biniodide of mercury and mercurial inunctions. For a time he got steadily worse and I did not think he could possibly recover.

There was a condition of dementia and for three weeks he had to have an attendant, as he would set fire to pieces of paper in his room. He was unable to dress himself, not for lack of strength, but he seemed not to know the use of the various objects about him. For example, he would try to put his stockings on his head. He would wander about the house and did not sleep much. The only indication of iodism he had was a diarrhea which was troublesome. The picture he presented at this time was distinctly one of terminal dementia.

On February 29, about a month after my first examination of him, I again made a careful examination of his condition. His general condition was fairly good; return of strength, but still showing greatly exaggerated reflexes. The eye ground showed the discs pale and well defined, especially to the left. The pupils were dilated and reacted rather sluggishly. The hemianopsia had nearly entirely disappeared. His mental condition was still distinctly below par; his memory was bad and his general appearance complacent; laughing frequently in a silly and meaningless way.

There is a complete blank in his memory from January 15 to February 15. He says that during this period he thinks his mind was occupied with Arctic exploration, about which he had probably been reading. I saw him again on September 9. He seemed in perfect physical condition. There was

no paralysis, the reflexes were about normal and there was no trace of the hemianopsia. He says that his memory is about as good as ever, though his physician thinks it still impaired. He seems to lack concentration, and is not inclined to get to work.

The treatment of this case might perhaps be considered heroic, though the results were gratifying. When I first saw him January 21, he was put upon rapidly increasing doses of potassium iodide until he reached 480 grains a day. This daily dose was continued for three weeks, then reduced to 180 grains, which was continued until June 1. Since that time he has been taking 30 grains a day. At first for three weeks he had two mercurial inunctions a day and for three months ⅛ of a grain of the biniodide of mercury. During all this time there was no evidence of iodism or salivation except the diarrhea mentioned.

Case II. This case illustrates another phase of cerebral syphilis. Mr. T., aged 43, was brought to the City Hospital February, 1896. He had fallen on the street and the attack was, from the history, epileptiform. On March 18 he had another similar attack and fell and became unconscious. In both these attacks the left side was apparently involved, since he was rather weaker on that side for some days subsequent to the attacks. On the 4th of May last he was brought to the City Hospital after having had another attack. He remained as a private patient for about two weeks.

During the greater part of his stay at the hospital he was in a state of stupor, and after he regained full consciousness his mental condition was not good. He seemed in a state of exaltation, and was very anxious to go to work, and in fact left the hospital before he should. On the 29th of May of this year while sitting at the table he suddenly dropped his knife and fork, his face became pale, he frothed at the mouth and his limbs jerked, mainly on the left side. After this attack he was unable to walk for ten days. From the time he left the hospital, on May 4, until this time he had been taking potassium bromide with moderate doses of iodide.

Syphilis was suspected, but he did not admit having had the disease until after this last attack. He was then put upon large increasing doses of iodide, but, as his wife told me, did not take the medicine very regularly and would not come to my office at the times appointed, assigning as a reason that he was all right and did not need any more medicine. The condition of exaltation became more pronounced and when irritated he was difficult to manage. His mental condition became progressively worse and he had a number of attacks. The history of the attacks showed them to be distinctly epileptiform, though after the attack there remained a certain amount of general weakness, particularly on the left side.

It was suggested that he submit to an operation and after some weeks he was brought to the hospital for that purpose. By this time he was maniacal and his general condition was so bad that it was thought best not to interfere surgically. Besides, there was very little to go on for localization. He had complained for months of headache but the pain was not localized, and the weakness in his extremities, which had formerly been most marked on the left side, became general. An ophthalmic examination made about June 1 showed the discs blurred and the vessels thin and tortuous. His condition grew gradually worse in spite of the vigorous pushing of the iodides and mercurial inunction, and he died the latter part of August.

Case III. John L., a patient at the City Hospital, with a history of syphilis dating back three years. Patient complained of intense pain in his head and percussion over the head showed the whole left half of the skull to be extremely sensitive. There was no rise of temperature. He suddenly developed unconsciousness, with spasmodic twitching on the right side. In a day or two there developed a left hemiplegia. Mercurial inunction was vigorously pushed, and in the course of a few weeks the paralysis disappeared. This patient never regained his mental balance per-

fectly, and is now an inmate of Bay View Hospital.

Case IV. This case need not be referred to except that it was curiously similar to the preceding one. A man about 25, seen in consultation with Dr. W. T. Riley. When I saw the patient he was comatose, with convulsive twitchings on one side, and this condition had developed gradually. He was put upon vigorous mercurial inunction and iodide as soon as he could swallow the latter and had recovered with slight loss of power on the side opposite the one in which the spasmodic movements had occurred.

Case V. This patient, a woman of about 40 years of age, I have seen from time to time during the past five or six years. She first had an apoplexy, leaving a hemiplegia, and afterwards developed a very marked polyuria. I have always regarded the case as distinctly one of syphilis though antisyphilitic treatment has had little effect.

Case VI. A man 31 years of age, with a history of syphilis dating back 10 years. In this case there was the history of imperfect treatment of the early stage. In April, 1896, he had paralysis of both external recti muscles which lasted for four months. About the middle of August he developed a ptosis of the left eyelid, which rapidly became complete and soon after the movements of the eyeball were affected. Two weeks later the right eye became involved in exactly a similar manner. When I saw him in September he had complete double ptosis, and the only movement he was able to make with his eyes was a slight outward rotation of the right eye. At this time he had at times, and without any cause, an extreme rapidity of the pulse, reaching 140 or over. There are no symptoms of the involvement of other parts of the nervous system. He has distinctly improved under specific treatment, though the movements of his eyes are yet very limited. These cases are very briefly mentioned, without going into the details of the histories, in order to illustrate some of the most important symptoms of cerebral syphilis.

Nothing has been said about the therapeutic test in the diagnosis of cerebral syphilis, because I think we should make up our minds concerning the case and then treat it vigorously. It is a notable fact that we get better results in the treatment of late manifestations of syphilis, especially syphilis of the nervous system, in this country than are obtained on the Continent, and I am firmly of the opinion that this is on account of the far more vigorous nature of the treatment in this country. It is the experience of most American neurologists that cases that have been treated with moderate doses of potassium iodide with slight benefit will often recover under the heroic doses, with perhaps mercury in addition. By heroic doses I mean from 300 to 500 grains of iodide a day.

This looks, as somebody has said, like a waste of good medicine, but there can be no doubt of its efficiency. Until we have some clearer knowledge of the physiological action of the salts of iodine we are justified in this empirical method of administration.

Finally, it is possible that a certain number of cases of cerebral syphilis are regarded as cases of general paresis, and no vigorous treatment employed, and that, too, at the time when this treatment would be most effective. The plea then that I would make is for more exactness in diagnosis and a more vigorous exhibition of iodide of potassium and mercury. There can be no doubt of the fact that the administration of mercury either in the form of the biniodide or as an inunction very materially aids the action of the potassium iodide.

WOMAN'S MILK AND ANTITOXINE.

SCHMID (*British Medical Journal*) thinks that the protective material taken up in the mother's blood during treatment passes into the milk, though in smaller relative proportions. Sucklings rarely contract diphtheria. He insists that, in association with the subject of antitoxine treatment of mothers with diphtheria, it is necessary to ascertain how long the infants' blood naturally resists the diphtheritic poison.

CONTINUED FEVERS.

By C. Birnie, M. D.,
Taneytown, Md.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, HELD AT HAGERSTOWN, MARYLAND, NOVEMBER 10 AND 11, 1896.

By continued fever I mean a fever lasting from two weeks to six weeks, or sometimes longer, lacking the characteristic symptoms and lesions of typhoid or malarial fever and not due to any definite lesion.

Two typical cases that occurred in my practice during the past summer will serve to illustrate the course of the disease.

Miss X, aged 35, with a good family history, never had any illness and never had a physician visit her professionally, had been complaining for a few days previous to June 24 last, of irregular appetite, constipated bowels and general malaise. On that day, while temporarily assisting her brother-in-law in his drug store, she was taken with a slight chill, followed by nausea and a feeling of faintness.

When I first saw her she was feeling weak and faint, skin pale and clammy, pulse 60, feeble and of small volume, constant nausea and occasional vomiting, temperature 97.5°. A few hours later the nausea and vomiting were somewhat relieved, temperature normal, pulse 70, still weak.

Her temperature rose gradually until the third day, when it reached 103°. Her fever lasted two weeks, the temperature never getting above 103° and never falling below 100.5°, the pulse ranging from 80 to 100. The nausea passed away after the first week and did not return but twice, when it was due to error in diet.

Convalescence was rapid and she is now in her usual health. The diagnosis was by exclusion. There was no diarrhea, the bowels being slightly constipated ; no tympanites, no spots, no hemorrhage, no delirium, no stupor, no characteristic rise of temperature, nor at any time marked debility. There was a morning remission and an evening exacerbation, as there is in all fevers, but it was not regular.

Malarial fever was excluded by the absence of regular remission and by the fact that antiperiodics had no effect whatever on the disease. A careful examination of all the organs failed to show any lesion which would account for the fever. There was a little gastric catarrh, possibly a slight enlargement of the spleen, and the urine was high-colored fever urine, but entirely free from albumen or sugar.

She accounted for the persistence of the nausea by attributing it to disgust at the smell and appearance of medicine in her weak condition. I think it was a contributory cause, for the sight of a bottle with a label on it would cause violent retching and I was obliged to have the bottles of medicine kept out of her sight.

The treatment was symptomatic ; hydrocyanic acid, cracked ice and counter-irritation for the nausea, and as the fever continued after the gastric symptoms had subsided, I gave her quinine to cinchonism, but without the least benefit ; after that it was only given in tonic doses during convalescence. The rest of the treatment was small doses of mineral acids, or lemonade, laxatives occasionally when needed, large enemata and cold sponging. The fever gradually left and her convalescence was rapid and complete. The only definite and constant symptom in the case was the fever.

The next case was that of a farmer, aged 43, typically strong and healthy. He was taken with a slight chill, some loss of appetite, a little dizziness, slight aching in the head and back, a pulse of 100, and when I first saw him on the third day, a temperature of 102°. This condition of things lasted for three weeks, when his fever left and he recov-

ered rapidly. I could discover no lesion to account for it after a careful examination of every organ in his body.

This case bore most resemblance to a case of epidemic influenza, but the absence of bone pains, or any catarrh, together with the fact that there were no other cases of influenza in the neighborhood at that time, served to exclude it. The fever was the only constant symptom and that was so mild that it confined him to bed for only a small portion of the time. I might also add that all the distinctive symptoms of this so-called walking typhoid were absent.

The cause of this fever is not known. I have seen it follow fatigue, exposure to the sun, or to wet, errors in diet, drinking stagnant water, anxiety and mental overwork. Of course there is a disturbance of the heat centers, but what causes that disturbance is not yet known, whether it is due to a microbe, or as Da Costa suggests, to leucomaines, remains to be proved ; it is rarely fatal anywhere and with us almost never.

The principal symptom is a continued fever. Generally there is loss of appetite, often constipation and of course fever urine. The percentage of deaths is very small. Dr. J. M. Da Costa, in an article on this subject in the *American Journal of the Medical Sciences* for June, 1896, says of the few post-mortems : "No lesions are found except congestion of internal organs. The spleen is not markedly enlarged; slight meningeal exudation has been occasionally noted. I know of no accurate blood examinations."

The diagnosis is by exclusion. Leaving out of the question hysterical fever, which we rarely see in this country, the continued fever which sometimes attends arterio-sclerosis and that which sometimes attacks lithemics, this fever is more likely to be mistaken for typhoid fever, malarial fever and epidemic influenza. I have also seen one case of acute miliary tuberculosis mistaken for continued fever.

I have heard it said in this Faculty and seen it stated in different medical journals, that many of the cases in country districts, that were diagnosed as continued and malarial fever, were really typhoid, and that the diagnosis was due to the fact that physicians were unwilling to acknowledge the presence of typhoid in the vicinity. This certainly has not been the case with us, for until lately the tendency was to call everything typhoid. Whether the advent of the summer boarder would alter the case or not, I do not know. Just now it is more in vogue to call fevers that are hard to diagnose, malaria. I believe, however, that there is a distinct type of fever which is neither malarial nor typhoid and which in uncomplicated cases almost always ends in recovery, at least in this latitude. Further south in the United States it is occasionally fatal and in the tropics oftener so.

It is distinguished from a malarial fever in the absence of any regular or decided intermission by a microscopical examination of the blood and by the fact that antiperiodics have no effect on it whatever. From typhoid fever by the absence of all its distinctive symptoms, by its very low death rate and by the fact that there is very seldom more than one case in a family. From epidemic influenza it is diagnosed by the absence of any epidemic. It is neither contagious nor infectious ; there are no bone pains and fever or very slight symptoms of catarrh of any of the organs.

There are cases of grippe, however, in which the catarrhal symptoms are confined to the stomach and intestines, which are hard to diagnose from continued fever.

The prognosis is almost always favorable. I have seen but one fatal case, and that was complicated with despondency. Twenty-five years ago, medical students heard a lecture on this disease, and the books on the practice of medicine written at that time all noticed continued fevers; within the last few years the subject has been discussed in some of the Southern medical societies ; for a time, the subject seemed to be entirely lost sight of, and in more than one instance, both in medical societies and in journals, I have heard the idea that there was such a disease ridiculed.

More than once in my practice when a consultation decided that simple continued fever was a myth, I have reluctantly consented to having the patient dosed with antiperiodics, which answered no purpose but to make the patient more uncomfortable, or I have seen families uneasy as to the spread of typhoid and using every precaution, when I was certain the patient did not have typhoid.

When I am certain of my diagnosis, I treat these cases symptomatically with hydrocyanic acid, bismuth, cracked ice, etc., for nausea ; acid drinks or an effervescing draught, large enemata, laxatives when necessary; baths, wet packs or cold sponging when the temperature rises too high. Antipyretics given to reduce the temperature or to shorten the disease are not only useless but harmful; given in small doses frequently repeated, they relieve headache where that is a troublesome symptom. I prefer phenacetine in doses of from 2 to 4 grains.

The chief gains in making a correct diagnosis of this disease are to avoid useless medication and to save anxiety. Where the diagnosis is obscure it is often necessary to give a full dose of quinine tentatively, but harmful to continue it if it does no good. And now, when quite a number of our professional brethren believe that typhoid fever can be aborted or cured by purgatives and antiseptics, or by huge doses of antipyretics, it is surely a gain to humanity if we can conscientiously abstain from giving them.

THE CYSTOSCOPE IN DISEASES OF THE FEMALE BLADDER.

By J. M. Hundley, M. D.,
Associate Professor of Diseases of Women and Children, University of Maryland.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, HELD AT HAGERSTOWN, MARYLAND, NOVEMBER 10 AND 11, 1896.

HERETOFORE the treatment of no class of cases has been so unsatisfactory as diseases of the female bladder. Prior to the use of the cystoscope in these cases we had to be content to give drugs by the mouth and, in addition, in the severer cases, wash out the bladder with some solution. That is about all that was formerly done. It is true, for a number of years we have been able to inspect the urethra and limited areas of the bladder by means of the endoscope, but never as can now be done.

This newer cystoscope and the method of using it, the invention of Dr. H. A. Kelly, makes it possible to treat diseases of the female bladder with ease and precision. I am convinced by results already gotten by the use of the cystoscope, that the bladder is more frequently subject to organic disease than is usually believed, and that the various extrinsic causes thought to affect the bladder will greatly diminish in number as our knowledge increases, as will also functional diseases of the organ.

It has been much too common a practice with us all when a woman applied for treatment of bladder symptoms, more or less prolonged, to immediately suggest as the cause uterine or ovarian disease, or some malposition of the uterus; when no disease of those organs were found, to conclude that the trouble was simply what is called " a nervous bladder." I do not find fault with this manner of procedure and I should further urge the importance of keeping in mind the part rectal diseases play in the production of irritable bladder.

What I wish to emphasize is the necessity of going a step further in making a cystoscopic examination in each case where any doubt exists. If this be made a routine practice we will be amply repaid by seeing many of these intractable bladder cases yield to treatment in a surprisingly short time, when

compared to the time consumed by the older methods. I wish now to ask your attention to the following cases. The first case shows very clearly the value of the cystoscope, especially in the treatment, which will be brought out fully in the history.

Mrs. C. consulted me about one year ago on account of frequent and painful micturition. At that time I obtained the following history: She was 35 years of age, married, no children or miscarriages. She menstruated regularly and without pain; no leucorrhea; her bowels moved regularly. In April, 1895, her first bladder symptoms appeared and at the same time a dragging pain in the left iliac region. She had been in excellent health up to April, 1895, except for an attack of scarlet fever in the winter of 1891, from which she fully recovered. She was exceedingly nervous when I saw her. She was referred to me by her attendant in the belief that her bladder symptoms and nervousness were due to some uterine or ovarian disease. It was thought that the left tube and ovary were at fault, as she developed pain in the left iliac region about the beginning of her bladder symptoms. When she consulted me she said her bladder trouble had progressively grown worse and that if she were on her feet for any length of time she was compelled to void her urine every fifteen or twenty minutes.

She had taken the usual remedies ordinarily given for irritable bladder without any relief whatever. Several examinations had been made of her urine with negative results. I made at this time a vaginal examination as well as I could without an anesthetic and found her pelvic organs free from any gross pathological lesion; her uterus, however, had descended in the pelvis somewhat, and feeling very sure that her symptoms being due most probably to a general nervous condition, more for the moral effect than any real good that would be accomplished, I introduced a ring pessary. In passing my finger into the left lateral fornix at the time of the vaginal examination, she evinced great pain. I could not make out that the left ureter was enlarged and therefore ascribed the pain to ovarian tenderness. I prescribed at the time bromides for the nervous condition and hot vaginal douches for their known sedative effect upon the bladder.

I did not see my patient again until sometime in April of this year, an interval between her visits of about six months. At the second visit she said after leaving me in September, 1895, her bladder symptoms, nervousness and pain in the left iliac region did not improve, but grew worse. In December she first noticed blood in her urine, which sometimes appeared in clots, and again the urine was simply a very dark brown and was voided every fifteen or twenty minutes. She had to lie down most of the time and experienced constant pain over the region of the bladder, the pain frequently radiating down her legs and up into the lumbo-sacral region. Her nervous state was now very much worse than when she first visited me. Strange to say she did not void her urine more than three or four times during the night, while in the day it was every fifteen to twenty minutes. At this visit I strongly urged a cystoscopic examination of the bladder as I felt convinced the trouble was with the bladder and not due to some extrinsic cause. In the interval between her visits to me she had been persistently treated with oil of sandal wood, benzoate of ammonia, tonics, rest, etc.

She did not entertain the proposition to examine her bladder at this time and I saw her no more until the 10th of last August, when a cystoscopic examination was made of the bladder at her home. She was put in the knee-breast position and with a portable storage battery and an electric headlight, the entire interior of the bladder was carefully inspected through the cystoscope. Cocaine was applied to the urethra, which made the introduction of the cystoscope an almost painless procedure.

Our first impression while inspecting the bladder was that we had a papilloma to deal with from the dark color of the lesion, which lesion was situated on the lateral wall of the bladder about

three centimeters above the right ureteral opening. It was found, however, that the color was due to a large blood clot, which was easily removed with a cotton-wrapped probe. After removal of the blood clot an extensive ulcer was seen, irregular in outline and about one and a half centimeters long by about a half centimeter wide. It was a typical ulcer with shelving edges and a greyish necrotic base, which bled freely when touched. There was considerable edema of this area of the bladder more marked about the ureteral opening. There was a second ulcer not so deep or extensive as the first, situated on the anterior wall of the bladder in the median line about where the bladder and urethra merge into each other. It was somewhat difficult to bring this ulcer readily into view on account of the abrupt ballooning out of the bladder from the urethra. I forgot to say that her bladder had been washed out daily with a saturated solution of boric acid during the month of July without improvement in the bladder symptoms or decrease in the amount of blood in her urine.

The treatment pursued by us in the case consisted in making direct applications to the ulcers of a ten per cent. nitrate of silver solution every two or three days, with daily washing out of the bladder with a saturated solution of boric acid. The treatment was discontinued during the menstrual period, which lasted seven to ten days of each month. A twenty-five per cent. nitrate of silver solution was substituted for the weaker solution within a month, as improvement was not as rapid as we wished under the weaker solution. Washing out of the bladder with the boric acid solution was discontinued at this time. After each application of the nitrate of silver solution with the bladder free from urine about half an ounce of a ten per cent. ichthyol gelatine ointment was put into the bladder and ordered to be retained one hour.

From this time on there was marked improvement in the frequency of emptying the bladder. Where formerly urine was voided every fifteen to twenty minutes, the intervals between micturition increased to an hour, one and a half hours, two hours, two and a half hours, until now the urine can be retained three and a quarter hours with but little discomfort. The case is now about well. The smaller ulcer on the anterior wall of the bladder is well, and the larger ulcer is no longer excavated. Our patient is bright and cheerful, is no longer nervous and can spend an evening at the theater without discomfort from her bladder.

Early in the treatment of the case cover-glass preparations were made from the debris taken from the ulcers with the view of aiding us in arriving at some definite conclusion as to the cause of the bladder condition. Examination of the specimens showed mono-and polynuclear leucocytes, red blood corpuscles, bladder epithelium and a diplococcus occurring in pairs and clusters of fours. It was not satisfactorily determined what part the diplococcus played in the production of the ulcers. Tubercle bacilli were not found. Examination of the urine showed it to be acid.

Specific gravity 1025, a trace of albumen, no casts, pus cells, cocci free in the urine, bladder epithelium and red blood corpuscles.

The second case which I wish to report is of some interest from the standpoint of diagnosis. Last September I was asked to see, in consultation, Mrs. G., who had been passing large quantities of bloody urine since March. The blood was not constantly present in the urine; at one time she voided perfectly normal urine as to color, while the next time it would be almost pure blood. Her urine had been previously examined a number of times and nothing abnormal was found except red blood corpuscles. Frequency of urination varied from day to day. Some days she voided urine every half hour. Again she would go for twelve hours without being able to pass it, though suffering pain and having the greatest desire to do so. She had to be catheterized when these attacks of retention of urine came on before being relieved. This patient had lost a great deal of blood

from March to September, when I saw her. She had been most of that time in bed and she looked very anemic and had difficult breathing upon the slightest exertion. She did not seem to suffer any pain in the region of the bladder or kidney. Her blood was examined for malarial organisms as well as for the filaria sanguinis hominis with negative results.

Cystoscopic examination was made of her bladder with the view of determining whether this blood in her urine came from some growth in the bladder, or from the kidney. Upon examination the mucous membrane of the bladder was pale, very much paler than in health, and there was not a congested spot or anything abnormal found in the bladder. The case then resolved itself into one of hematuria, due doubtless to some blood dyscrasia. To have been able to state with positiveness the condition of the bladder in this case was of the greatest value and shows a great advance over older methods.

Other cases attesting the value of the cystoscope in this line of work could be added to those herein reported, but I think sufficient has been said to substantiate the claims set forth.

Society Reports.

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

SEMI-ANNUAL MEETING HELD AT HAGERSTOWN, MD., TUESDAY AND WEDNESDAY, NOVEMBER 10 AND 11, 1896.

TUESDAY, NOVEMBER 10, FIRST DAY.

The President, Dr. Wm. Osler, in the chair and Drs. John S. Fulton and H. O. Reik, Secretaries. Dr. J. W. Humrichouse, President of the Washington County Medical Association, then delivered the address of welcome as follows :

"Gentlemen of the Medical and Chirurgical Faculty, we welcome you again to Hagerstown.

"It is an honor we appreciate to have the Medical and Chirurgical Faculty of Maryland with us.

"A hundred years of existence have invested it with dignity. For almost a century inspired by the most worthy men of the profession it has been a powerful agent for the advancement and diffusion of medical learning and for the instilling and cultivation in medical men of lofty ideas regarding their most ancient calling today. It comes to us with men of the University of Maryland, of the Johns Hopkins, the Baltimore Medical College, the College of Physicians and Surgeons, with men of all the hospitals and schools of the State, and invites us to partake of the influences it has so long represented.

"We recall with pleasure the first visit in November, 1889, of the State Society in Hagerstown. One of the results of that meeting was the reorganization of our County Medical Society, which now numbers about 35 active members, who assemble quarterly to read and discuss papers and to become better acquainted with each other.

"Another result we are glad to know was the encouragement it gave the Faculty to meet in other towns of the State.

"Now the medical profession of the whole State is interested in the object and aims of the State Society. The county member is no longer isolated, no longer left to himself, to become narrow-minded, but in touch with the spirit which animates this organization of which he has become a part.

Dr. William Osler, the President, responded on behalf of the Faculty. We are only too delighted to meet here among you. I think that one of the most immediate and pressing needs of the ancient and honorable Faculty of Maryland is that the members throughout the State at large shall take a greater interest than they do in the affairs of this institution. I have had the pleasure of being a member of the State Society in Pennsylvania and of similar societies in Canada, and I am impressed with the idea that the members of this State have not taken as much interest in the affairs of their society as they should. The Faculty belongs to the physicians of the State and not alone to the profession of Baltimore. There is now a membership of 475, and of these

139 are members from the State at large and 336 from the city of Baltimore. There are 761 regular practitioners in the State outside of Baltimore, so you see the proportion of members is not a proper one. There are about 1000 physicians in the city of Baltimore, of whom 336 are members of the State Faculty. The proportion in the city, as you see, is considerably larger.

As many of you know, the Faculty has within the past two years taken a new lease on life, and we have now our own property, a very nice hall and a good library, which is increasing very rapidly. We have had some large bequests lately, and the members of the Faculty can now find in our library almost any periodical in any language, and, in fact, we have the third or fourth largest list of current medical literature in the country. Owing to the kindness of the Frick family we have a beautiful reading room, superbly furnished, and all of the new books in the department of medicine which Dr. Frick represented. I hope that at an early day we shall be able to give the county members of the Faculty equal advantages with the city members in procuring the use of these books. For instance, if one of you should want a book, I hope that arrangements may be so made that you can telegraph our librarian for it and have it sent out at once. There is no reason why you should not have the privilege of using the books in that way.

Your attention might be called also to the nurses' directory. We hope you will take an active interest in that, and when a nurse is wanted telegraph for one to the library, where a list is kept and where they can be obtained at the earliest possible moment.

Dr. C. Birnie of Taneytown then read a paper on CONTINUED FEVERS. (See page 132.)

Dr. J. C. Hemmeter: I would like to ask Dr. Birnie what he thinks of the so-called gastric fevers. I have met a number of people that believe in them. It seems to be a fever that does not resemble the well-known exanthemata, and the organism, if there is one, is confined possibly in the blood.

Dr. Birnie: So far as a microscopical examination of this fever is concerned I think there is no history whatever of it. I have not been able to find any. I could only examine my own private library, however. Gastric fever I have always thought was a form of gastric catarrh. The fever of which I am speaking you could hardly call gastric fever because the symptoms that usually occur in disturbances of the gastric organ are here almost nil.

Dr. William Osler: I have no personal knowledge of gastric fever.

Dr. Charles M. Ellis of Elkton: I have recently had similar experiences to Dr. Birnie's, and my conclusions are that the continued fevers have some connection with sthenic fever. A case in instance was that of a lady who while traveling from New Orleans to Elkton, was taken sick on the way. It was excessively hot, the temperature in the cars averaging from 85° to 90°. She was taken with a chill on the train before arriving at Elkton. She had no epistaxis or coughing, but had a regular diurnal rise and fall of temperature and some gastric symptoms. There was no enlargement of the spleen and no evidence of typhoid fever. I think her trouble was the result of exposure to the intense heat, for I have had several similar cases that seem to have their origin in such prolonged exposure.

Dr. A. S. Mason of Hagerstown: Such cases as have been spoken of have come under the observation of most practitioners of medicine. I recall so many of them that I consider it hardly necessary to mention any individual case. The fact seems to be established that quinine relieves all malarial troubles. Now, how can you classify those cases that can be excluded from the type of typhoid fever and yet give no answer to the preparation of bark? Many of these cases have come under my observation in the last forty years and quinine has been used for them even in large doses without any benefit. I recall two cases contracted some years ago upon the coast of Florida. They lasted from four to six weeks and quinine did not seem to affect them. One

of the patients was a lady who now resides in this town. In neither case was there any local lesion. During the present week I have seen a similar case in a child. It simply had a protracted fever which had lasted for four weeks and then subsided. In this case there was no lesion and again quinine had no effect. You all recall an epidemic in this city ten or twelve years ago, when it was said that we were having malaria all along the coast. We had typhoid at the time, caused by pollution of our drinking water, but any number of the cases we saw then had none of the characteristics of typhoid and after running a course of four or five weeks subsided. I would like to know how to classify such fevers.

Dr. Geo. J. Preston: The discussion of the diagnosis of irregular fevers is certainly of very great importance. Of course our whole knowledge of fevers as yet needs to have a great deal of light shed upon it.

When we go back to the physiological explanation of fever and attempt to balance the heat production with the heat loss we see how ill-balanced they are. Even our knowledge of thermic centers is very far from being exact. We know of certain centers in the medulla, in the basal ganglia and possibly higher up. I sometimes think we do not give due weight to the physiological aspect of the question.

The question of fevers due directly to some psychic stimulation is of importance. There is no doubt that we do have some hysterical fevers; that is accepted by neurologists, and there is in these cases a distinct rise in temperature. The diagnosis of such cases is, of course, almost impossible. Fortunately we rarely meet with them. We frequently have typhoids that run a somewhat similar course to that described by Dr. Birnie, and are called occasionally walking typhoids. They run for three or four weeks. The temperature rises slowly, there may be no tympanites and no eruption noticeable, but by the end of three weeks a relapse comes as a clinch to our diagnosis. The enlargement of the spleen and liver is not diagnosed, and the diazo-reaction has not in my hands proven of great value. It is to be borne in mind that we have cases of malaria, in the city at least, where quinine seems to give no benefit. There is always a fluctuation, of course, but I have seen these cases run for several weeks resisting quinine.

Correspondence.

TEMPERANCE AND BRIGHT'S DISEASE.

BALTIMORE, November 30, 1896.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—Apropos of your editorial last week—*Plures crapula quam gladius!* Rather, much rather, would I be a steady drinker (say one bottle of beer and a glass of whiskey daily) with a moderate appetite than a teetotaler with a large one. Over-eating is as much a cause of degeneration of arteries and of kidneys as over-drinking. Harris, the caterer, will tell you that for a temperance dinner or supper much more food is provided than at a rational, Cana-in-Galilee-like, feast at which wines are served. There is death in pot and cup alike. *Ab intempestivis commessationibus*—to quote the immortal Burton.

Yours very truly,

CRATINUS.

A CORRECTION.

ROCKVILLE, November 30, 1896.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—Please make the following corrections in your next issue, as without them my piece would lack merit. Instead of "I gave seven and a half grains of salicylate of sodium in a teaspoonful of essence of peppermint," it should read "essence of pepsin," and where it reads "a sixtieth of a grain of strychnine, hypodermically, during the remaining period of his illness," it should read "a sixtieth of a grain of strychnia, hypodermically, every four hours during the remaining period of his illness, as also the fluid extract of digitalis." Yours very truly,

EDWARD ANDERSON, M. D.

MARYLAND

Medical Journal.

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MARYLAND MEDICAL JOURNAL,
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BALTIMORE, DECEMBER 5, 1896.

THE usual effects of properly applied exercise not only produce a sense of exhilaration and a feeling of well-being but when conducted along certain lines and governed by scientific principles it brings about certain remote and permanent effects. In the Bible it is asked who can by taking thought add one cubit to his stature.

The Influence of Exercise on Growth.

Surgeon Henry G. Beyer of the United States Navy has given the subject considerable thought and he thinks he has added markedly to the stature of many cadets who took exercise according to his directions. His careful and practical article in the *Journal of Experimental Medicine* shows how systematic exercise adds not only to the height, but to the weight and strength.

He first studied the normal growth tables from the sixth to the twenty-second year. These tables were obtained from various and reliable sources. He then began the task of measuring each cadet passing under his care and he recorded the comparative measurements on entrance, during a carefully graded course of exercise and at the end of this period. His results are not only valuable but the manner is which he so intelligently uses his statistics is extremely praiseworthy. He found the most rapid growth between the fifteenth and twenty-first year to be in the fifteenth and next in the sixteenth year. Between sixteen and twenty years he found that properly administered gymnastic exercise showed an increase in height above the normal growth of 26.6 millimeters, or a little more than one inch. If the height is increased it follows naturally that in the large majority the weight and the strength are also increased.

Height is the most important consideration in this kind of investigation because any agent influencing growth in height in man influences growth in bone. Growth practically ceases at twenty-one while increase in weight and strength may be obtained almost indefinitely. The increase in strength from this kind of exercise was almost marvelous and he is inclined to think that almost any healthy young man can become a "phenomenal giant" if he exercise systematically and regularly.

The kind of exercise needed is not that which will alone increase the weight and strength, but also that which will increase the height, and then the other form of increase will follow as a matter of course.

This work of Dr. Beyer is especially interesting as showing why the young child should not be allowed to "just grow up" like Topsy, but should be given a systematic and regular course of training as laid down by this writer so that a race of strong and tall men may have the opportunity to marry and bring into the world strong and healthy offspring to counteract the many degenerating and enervating effects of the style of living of the present day.

* * *

THE simpler diseases rarely excite the interest of physicians; indeed such troubles as acute rhinitis are so familiar that they breed contempt in the opinion of Dr. Henry J. Mulford, in the *American Medico-Surgical Bulletin.*

Curing a Cold.

He has tried such old remedies as Dover's powders, full doses of quinine, the Turkish

bath, and all in his opinion are of no avail. He recites a number of cases to show that routine treatment is of little use and he endeavors to educate physicians to treat such apparently trifling disorders intelligently.

Two classes of persons are especially prone to colds. One is the patient subject to a diathesis and the other is the individual who persistently bundles and wraps himself up so that the slightest draft is dangerous. The first idea of treatment is to start the organs to functioning and clear effete matters from the circulation. This can best be done with calomel or podophyllin.

The diathesis must be overcome and the coddling patient must wear sensible clothing. Rubbers, which sweat the feet and cause a feeling of cold and clamminess, should not be worn. The patient and his nose must both be carefully examined and the treatment suited to each case.

Dr. Mulford has evidently studied his subject and has had no small experience in curing colds. It is refreshing to see the question handled in such an intelligent manner. The treatment of such simple troubles as colds is usually handed from one to another and there are few persons who have not on tap some sure remedy for colds, a remedy which they willingly pass to their friends and which they claim as a specific. Such judgment is, of course, based on a small experience by a mind uneducated in medicine.

The best way to cure a cold is not to have it; that is, so to train the body that when there is loss of heat, the heat-producing centers will rush to the rescue and make up for what is lacking and thus restore the equilibrium. It is astonishing how much heat can be extracted from the body by cold, wet feet, because, of course, the feet are usually the point of contact between the body and the ground.

Besides the avoiding of coddling and inhabiting rooms overheated with fires made by the heat-loving negro, the body should go through a course of hardening by cold douche baths which could be taken by those who can stand them throughout the winter. Exercise should be liberal, and good, strong food should be taken. The healthy individual takes a cold only when unusual conditions prevail and usually escapes chilling where the ordinary person would succumb.

The Frick Library Dedication.

THE Frick Library of the Medical and Chirurgical Faculty of Maryland will be formally dedicated next Thursday night, December 10, with appropriate ceremonies. With an untiring energy characteristic of a few members and officers of the Faculty, this memorial library has been added to the valuable facilities of the Faculty and the committee announces that the library will be formally opened to the members next week.

Dr. Samuel C. Chew, a life-long friend of the late Dr. Charles Frick, will deliver the principal address, reviewing his life. Mr. Reverdy Johnson, an old friend of Dr. Frick, will also be present and make a few remarks. Brief addresses may also be expected from Dr. J. M. DaCosta, President of the College of Physicians of Philadelphia, and by Dr. Joseph D. Bryant, President of the New York Academy of Medicine. After these ceremonies, which will not be long, a collation will be served.

This will certainly be a memorable event in the life of the Faculty, and the generous example of the Frick family may serve to stimulate citizens to leave some similar testimonial of their regard for the medical profession.

Formal invitations will be sent out to all members of the Faculty and all members from the city and State will be welcome.

* * *

Typhoid Diagnosis.

IT is a source of congratulation to note that the Health Department of Baltimore, acting on the hint conveyed in the last issue of the MARYLAND MEDICAL JOURNAL, will now arrange to have glass slides left at convenient stations in Baltimore so that physicians may leave the blood of suspected typhoid cases for diagnosis by the bacteriologist of the Health Department.

As this advance has been taken up as yet by very few health boards it is a great credit to the Health Department of Baltimore that such facilities are offered to the profession.

The value of this method need not again be emphasized. It is almost too early to predict what the effects of an early diagnosis will have on the mortality of this dreaded disease, but the step is a proper one and cannot but receive the approbation of the profession and the public.

Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending November 28, 1896.

Diseases.	Cases Reported	Deaths.
Smallpox		
Pneumonia		16
Phthisis Pulmonalis		22
Measles		
Whooping Cough	6	
Pseudo-membranous Croup and Diphtheria.	22	4
Mumps	1	
Scarlet fever	25	
Varioloid		
Varicella	2	
Typhoid fever	15	4

Bay View Hospital now has trained nurses.

Dr. George Harley of London died in October, aged 67.

Behring and Knorr report success with a tetanus antitoxine.

The Clinical Laboratory of the Johns Hopkins Hospital was opened last Monday. The children's ward will be opened later.

The New York Board of Health has under consideratiou the banishing of dogs from the streets. This is no small undertaking.

Diphtheria is reported to be prevalent in Powellsville, a small town near Salisbury, Wicomico County, Maryland. Dr. Fulton is investigating.

Dr. Edmund Lesser of Berne has been called to Berlin to succeed the late Dr. Lewin, the eminent dermatologist whose death took place recently.

The Anglo-American Continental Medical Society met last month in Paris. Dr. Halstead Boyland, formerly of Baltimore, is an active member.

The New Orleans University Medical School has in contemplation a plan for establishing a training school for negroes. The suggestion has received cordial support, and there are good reasons for believing that the undertaking will succeed.

The Hartford Medical Society celebrated the fiftieth anniversary of its existence in that city, October 27, 1896. The meeting was largely attended and many interesting papers were read. Dr. Gurdon W. Russell delivered the historical address.

At the last regular meeting of the Folk-Lore Society of Baltimore, Dr. Charles C. Bombaugh read a very interesting and scholarly paper on "Medical Superstitions," which was discussed by Dr. Henry M. Hurd of the Johns Hopkins Hospital and others.

Dr. Nicholas W. Kneass, who died last week at his home on North Charles Street, Baltimore, was a homeopathic physician of wide note and was greatly beloved by his friends and patients. He was a graduate of the Hahnemannian Medical College of Philadelphia.

Plans have been filed at the Department of Buildings of New York City for additional buildings to be erected in connection with Bellevue Hospital, at an estimated cost of $130,000. A water-tower is also to be built west of the City Hospital on Blackwell's Island.

Dr. Hunter Robb, who was formerly connected with the Johns Hopkins Hospital, has among other positions become a collaborator of the *Cleveland Medical Gazette*, which makes its appearance this month in a new dress and is now owned by a stock company of physicians.

San Francisco has opened four food inspection stations, much like the *octroi* of foreign cities. Here every wagon bringing in food products of any kind is stopped and inspected and stamped if passed. This does not apply to the markets. It is an excellent plan and cost that city $10,000.

Portsmouth, Ohio, physicians have adopted a resolution which requires all delinquent patrons to pay in advance for professional services. A common list for use of all society members has been prepared. Let the good work go right along. Symptoms of the contagious influence are to be treated phlogistically.

The death of Rokitansky, the Viennese opera singer, at the age of sixty, and son of the celebrated Austrian pathologist, who also had a son a physician, recalls the answer given by Rokitansky, Sr., when asked what his sons did. He said: "*Der eine heilt und der andere heult*," *i. e.*, "One heals and the other howls."

Book Reviews.

THE STUDENT'S MEDICAL DICTIONARY. Including all the the Words and Phrases Generally Used in Medicine, with their Proper Pronunciation and Definitions. Based on Recent Medical Literature. By George M. Gould, M. D., A. M., etc. With Elaborate Tables of the Bacilli, Micrococci, Leucomaines, Ptomaines, etc.; of the Arteries, Ganglia, Muscles and Nerves; of Weights and Measures. Analyses of the Waters of the Mineral Springs of the United States, etc. Tenth Edition, rewritten and enlarged. Philadelphia: P. Blakiston, Son & Co., 1896. Pp. xii—17 to 701. Price, $3.25.

Although this is called a new edition, it is in reality a new dictionary entirely, as the plates of the old one have been destroyed. Dr. Gould has been very successful as a dictionary writer and in spite of certain peculiarities of spelling which no human power could induce him to change, he has written the best medical dictionary that has ever appeared. It does not contain the illustrations like the larger one, but the more commonly used words are included. This book has had an enormous sale and deserves its popularity. The pronunciation of doubtful words is given. It is unnecessary to add that the publishers' work is up to the usual high standard.

MANUAL OF PHARMACOLOGY AND THERAPEUTICS. By William Murrell, M. D., F. R. C. P., Physician and Lecturer on Pharmacology and Therapeutics at the Westminster Hospital, etc. Revised by Frederick A. Castle, M. D., Member of the Committee for Revision and Publication of the Pharmacopeia of the United States of America, etc. New York: William Wood & Co., 1896. Pp. 516; Octavo.

This work of Murrell has been revised by Dr. Castle and arranged for the American reader. Additional matter on climate and natural mineral waters has been added from other authors. The lectures of Dr. Murrell at Westminister Hospital have been abstracted and rearranged by the American editor. He gives a comprehensive definition of therapeutics and an interesting chronological history of the subject which is divided into such sections as: Sources of medicine, adulteration of drugs, the study of materia medica, pharmacological investigations, physiological actions, idiosyncrasy, tolerance and habit, accumulations, incompatibility and antagonisms, active principles and serum therapeutics.

Current Editorial Comment.

DISPENSARY ABUSE.

The Clinical Chronicle.

I FULLY believe the physician's abuse of the dispensary is greater than the patient's abuse of it. No doubt, there are numbers of physicians who utilize the dispensary as a means of enlarging their office practice. This is wrong from principle.

MEDICAL MEETINGS.

American Medico-Surgical Bulletin.

IT appears to us that physicians could employ their time more profitably than attending many of the medical meetings which occur. No worthy object is gained by reading or discussing papers which contain nothing new, and which in general may be found more succinctly stated in standard text-books. How much wider our knowledge, how much broader our culture, how much better doctors we would be, if instead of forever hobnobbing together on time-worn themes, we should devote these hours to literary kings and queens, or to little journeys into the territory of neighboring sciences.

HOSPITAL ABUSE.

Lancet.

THERE can be little doubt that the subject of hospital abuse is one of the greatest interest to the profession and that the profession is mainly responsible for the evils complained of. We cannot go so far as to acquit the subscribers to hospitals who supply letters of admission or out-patient letters promiscuously to all who ask for them. The responsibility of the profession depends on this circumstance, that hospitals are essentially medical institutions. The whole machinery and purpose of them are medical. The staff of the hospital, so to speak, is the *deus ex machinâ*. Take that away and the hospital has no ground of appeal to the charitable public. The services of the staff are gratuitous, and surely the very least its members can be expected to demand as a condition of their services is that there shall be no abuse of the charity they administer, and that it be not spent on persons who can afford to meet their own medical wants, who live in houses of £100 ($500) a year rental, or buy farms worth £10,000, ($50,000) or can afford to pay £40, ($200) for an operation, or who have an annual income of £4000 ($20,000).

Publishers' Department.

Convention Calendar.

NOVEMBER						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	..	..	..	..	..
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DECEMBER						
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27	28	29	30	31	..	..
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State Societies.

NOVEMBER.

27. NEW YORK STATE ASSOCIATION OF RAILWAY SURGEONS, at New York City. C. B. Henich, M. D., Secretary, Troy.

DECEMBER.

1. LYCOMING COUNTY (PA.), at Williamsport, Pa.
3. TRI-STATE, of Western Maryland, Western Pennsylvania and West Virginia, at Cumberland, Md.

National Societies.

NOVEMBER.

10. SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION, at Nashville. W. E. B. Davis, M. D., Secretary, Birmingham, Ala.

16-19. PAN-AMERICAN MEDICAL CONGRESS, at City of Mexico, Mexico.

DECEMBER.

30-31. WESTERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Herman E. Pearse, M. D., Secretary, Kansas City, Mo.

BALTIMORE.

BALTIMORE MEDICAL ASSOCIATION, 847 N. Eutaw St. Meets 2d and 4th Mondays of each month.

BOOK AND JOURNAL CLUB OF THE FACULTY. Meets 2d and 4th Wednesdays, 8 P. M.

CLINICAL SOCIETY, 847 N. Eutaw St. Meets 1st and 3d Fridays—October to June—8.30 P. M. S. K. MERRICK, M. D., President. H. O. REIK, M. D., Secretary.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE, 847 N. Eutaw St. Meets 2d Tuesday of each month—October to May (inclusive)—8.30 P. M. W. S. GARDNER, M. D., President. J. M. HUNDLEY, M. D., Secretary.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE, 847 N. Eutaw St. Meets 2d and 4th Thursdays of each month—October to June—8.30 P. M. W. S. GARDNER, M. D., President. CHAS. F. BLAKE, M. D., Corresponding Secretary.

MEDICAL JOURNAL CLUB. Every other Saturday, 8 P. M. 847 N. Eutaw St.

THE JOHNS HOPKINS HOSPITAL HISTORICAL CLUB. Meets 2d Mondays of each month at 8 P. M.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY. Meets 1st and 3d Mondays, 8 P.M.

THE JOHNS HOPKINS HOSPITAL JOURNAL CLUB. Meets 4th Monday, at 8.15 P. M.

MEDICAL SOCIETY OF WOMAN'S MEDICAL COLLEGE. SUE RADCLIFF, M. D., President. LOUISE ERICH, M. D., Corresponding Secretary. Meets 1st Tuesday in the Month.

UNIVERSITY OF MARYLAND MEDICAL SOCIETY. Meets 3d Tuesday in each month, 8.30 P. M. HIRAM WOODS, JR., M. D., President, dent. E. E. GIBBONS, M. D., Secretary.

WASHINGTON.

CLINICO-PATHOLOGICAL SOCIETY. Meets at members' houses, 1st and 3d Tuesdays in each month. HENRY B. DEALE, M. D., President. R. M. ELLYSON, M. D., Corresponding Secretary. R. H. HOLDEN, M. D., Recording Secretary.

MEDICAL AND SURGICAL SOCIETY OF THE DISTRICT OF COLUMBIA. Meets 2d Monday each month at members' offices. FRANCIS B. BISHOP, M. D., President. LLEWELLYN ELIOT, M. D., Secretary and Treasurer.

MEDICAL ASSOCIATION OF THE DISTRICT OF COLUMBIA. Meets Georgetown University Law Building 1st Tuesday in April and October. W. P. CARR, M. D., President. J. R. WELLINGTON, M. D., Secretary.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA. Meets Wednesday, 8 P. M. Georgetown University Law Building. S. C. BUSEY, M. D., President. S. S. ADAMS, M. D., Recording Secretary.

WOMAN'S CLINIC. Meets at 1833 14th Street, N. W., bi-monthly. 1st Saturday Evenings. MRS. M. H. ANDERSON, 1st Vice-President. MRS. MARY F. CASE, Secretary.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY. Meets 1st and 3d Fridays of each month at members' offices. GEORGE BYRD HARRISON, M. D., President. W. S. BOWEN, M. D., Corresponding Secretary.

PROGRESS IN MEDICAL SCIENCE.

THE State Board of Health of New York has asked for sufficient funds to employ a chemist to regularly examine and report on the beer product of that State, it being charged that beer as now manufactured is largely adulterated. The subject is creating considerable agitation between the manufacturers and the promoters of the movement. The Bartholomay Brewing Company, whose Baltimore manager is Mr. George C. Sucro, publish in connection with their advertisement the result of an analysis of their product by a professor of chemistry, expressed in percentages by weight, thus assuring all physicians who prescribe Bartholomay Beer that nothing enters into composition but malt, hops, yeast and water, and is entirely free from adulteration.

MACEY, CREAIGHEAD CO., ARK.,
July 12, 1895.

JNO. B. DANIEL, Atlanta, Ga.

Dear Sir:—The Passiflora Incarnata you shipped me on June 7 reached me direct. I have tried it in several cases where I thought it was indicated. It has given thorough satisfaction. Please duplicate my order at once, and oblige, Yours fraternally,

J. L. GIST, M. D.

PROGRESS IN MEDICAL SCIENCE.

AN INTERESTING EXHIBITION.

For the benefit of those of our readers who may have the opportunity an invitation is extended to all who can to witness the exhibition of the X ray apparatus now being given at the Chas. Willms Surgical Instrument Co. of Baltimore, by Mr. B. A. Nelson, the General Manager of the Company.

It is impossible to estimate at the present time the far-reaching influence that this latest product of modern science may exert, in opening up fresh fields to the scientific investigator. It is now possible to localize the exact position of bullets and other foreign substances in the human body, to minutely examine all fractures and displacements of the bones, and to observe the actual motions of the heart. The apparatus is so practical and its value so clearly demonstrated, it is safe to say that within a short time, doctors will no more undertake to operate where the bones are at all concerned, without first making a minute examination by the X ray, than they will attempt a diagnosis for tuberculosis without a microscope. The essential features of the apparatus are as follows: 1. The Crooke's Vacuum Tube. 2. The Edison Thoroscope. 3. The Ruhmkorff Coil. 4. A Battery or 120 Volt Direct Current.

Thoughts on Antitoxin.—In no remedy ever advanced for the treatment of disease are the results more marked and the effects more constant than in antitoxin. The claims established in the laboratory and ticketed upon it when it was enlisted in the service of man are still made and realized today. They have not been abridged nor supplemented. The prudent physician knows these claims and makes no other for the antitoxin he uses; neither does he lay to its charge effects it is powerless in itself to produce. Its effects are strictly limited to the bacillus diphtheriae and its toxines. As these are favorably acted upon the symptoms following in their trail will be promptly ameliorated. Deposited by the needle into the cellular tissue of the victim of typical diphtheria the antitoxin rapidly goes to bathe every cell of the body, neutralizing the depressant toxines in the system, the effect of which is to cool the fever and calm the heart. It invades the home of the bacilli carrying with it death and expulsion. The result is that the false membrane loses its vitality. It is seen to grow pale while gradually it is detached and expectorated. That antitoxin has its enemies is not to be marveled at. It would be more surprising were it otherwise. The enemies of antitoxin, ninety per cent. of them, are physicians who have never used it, while the remaining ten per cent. have, to say the least, never used a reliable preparation.—Jacob R. Johns, M. D., Philadelphia.

Pain and Rest in Diphtheria. — Dr. Eggers of Horton Place, St. Louis, reports in the treatment of an attack of diphtheria in a member of his own family, that, to obtund the pain consequent upon the injection of antitoxine serum, which ordinarily lasts from three to four hours, he exhibited Antikamnia internally, securing relief in a few minutes. In the treatment of any neuroses of the larynx, coughs, bronchial affections, la grippe and its sequelae, as well as chronic neuroses, clinical reports verify the value of codeine in combination with Antikamnia, the therapeutical value of both being enhanced by combination.

The remarkable clinical results which have been attained in the use of Passiflora would more than justify the bestowal of attention on this remedy by practitioners who have not as yet demonstrated its valuable properties. The preparation known to the profession as Daniel's Conct. Tinct. Passiflora Incarnata is announced in this issue of the Journal, by Mr. John B. Daniel of Atlanta, Georgia, who will be very glad to furnish literature on the merits and uses of the drug. Its exhibition in various nervous disorders, in quieting delirium, in typhoid and other fevers and in the nervous disorders of children during dentition, has elicited much valuable data which has been compiled for general information.

High Commendation.—We find it [Tyree's Litmus Pencil] extremely sensitive to minute quantities of acids and alkalies. For the practitioner in testing urine it will be invaluable because reliable and the indication it gives is distinct.—*The Lancet* (London).

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if used with a clean needle.

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It never nauseates

when given by the mouth.

Dose: 5 to 30 minims.

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