



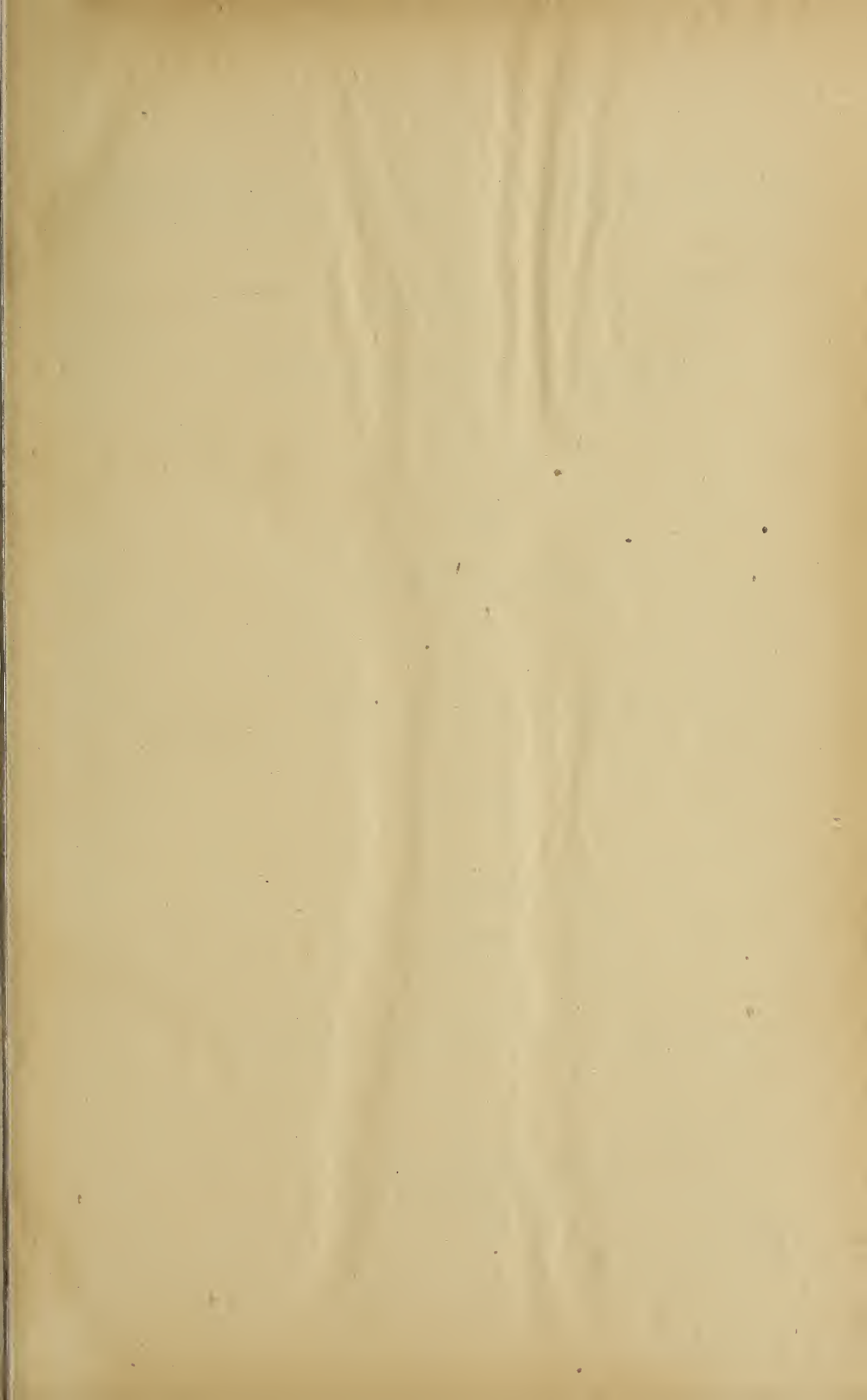


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# INDEX TO VOLUME XXVI.

PAGE.		PAGE.	
Abdominal Surgery, The Need of Training for.....	234	Cataractous Family, A.....	567
Act of England, Free Education.....	191	Catarrh, Acute, of Posterior Nares.....	556
Actinomycosis Hominis.....	416	Centennarian, A Medical.....	41
Ainhum.....	214	Cerebral Congestion Following Influenza, Blood-Letting for the Relief of.....	239
Albuminuria.....	212	Cerebral Hyperæmia Terminating Fatally, Case of.....	272
Alopecia Areata.....	345	Chancres, Genital, in Women.....	260
Anæmia of Girls.....	187	Chancroid, Etiology of.....	350
Anæmia, Hypodermic Injections of Sodium Chloride in.....	37	Cheese, The Bacteria of.....	478
Anæsthesia, For Accidents During.....	151	Chew, S. C., M. D.....	29
Anæsthesia, Local, for Slight Operations.....	85	Children, City Parks for.....	142
Anæsthetic, Water as a Local.....	302	Chloral, Influence of, on the Circulation..	38
Angina Pectoris, Nature of.....	566	Chloroform in First Stage of Labor.....	166
Antipyrine, Incompatibles of.....	17	Chorea and Epilepsy, Relations Between.....	505
Appendicitis.....	108	Chorea, The Relation of, to Rheumatism and Other Diseases.....	127
Appointments, Medical.....	499	Chorion, Cystic Degeneration of the.....	206
Arkansas Has It.....	504	Chronic Hydrocephalus, Treatment of, by Puncture.....	320
Aristol, A New Use for.....	19	Chronic Peritonitis, Cure by Laparotomy.....	41
Arteries, On the Torsion of.....	416	Cigar, New Use for the.....	39
Asphyxia.....	86	Clinical Cases, Recording of.....	431
Asphyxia, Nitroglycerin for.....	163	Cystitis, Medical Treatment of.....	129
Aspiration from the Patient's Standpoint.....	408	Cocaine in Hay Fever, Beware of the Free Use of.....	41
Association, The Latest National.....	121	Codeine, Notes on the Use of.....	119
Albuminuria. A Case of Physiological.....	191	Coffee, Truth About.....	124
Bacillus Diphtheria, Facts about.....	560	Condylomata.....	84
Bacterial Investigations, The Part Played by Leucocytes in Inflammation in the Light of Recent.....	199	Conjunctival Sac, What Little Inconvenience is at Times Caused by Large Foreign Bodies in the.....	465
Bangs, L. Bolton, M. D.....	287	Construction of Houses, The New Law Regulating the.....	384
Barnwell, C. C.....	441	Copper, Arsenite of, on the Wane.....	109
Beans, Artificial Coffee.....	103	Corn Plasters.....	87
Bill, A Medical Act.....	446	Corns Under the Nails.....	15
Bill, The Medical.....	473	Correspondence.....	168, 324
Bladder, Diagnosis of Tumors of the.....	16	Cystotomy, Supra-Pubic, Rationale and Technique of.....	137
Bladder, Irritable.....	418	Dentition, Third.....	259
Blindness, The Prevention of.....	385	Diabetes, Antipyrine in.....	414
Bond, A. K., M. D.....	450	Diphtheria.....	17
Books and Pamphlets..... 35, 125, 168, 255, 282, 298 342, 475 526,	562	Diphtheria, Treatment of.....	107
Bowel, Obstruction of the.....	23	Diphtherial Infection of Tracheotomy Wounds.....	345
Breast Milk, Notes on.....	79	Disease, The Blood in.....	508
Bromism, The Treatment of.....	40	Disease, Circulation Element in the Inception of.....	296
Bronchitis, Prescription for.....	370	Dispensaries, Free, or The Physician and the Poor.....	353
Buffy Coat, The.....	325	Dispensaries, Free; Their Relation to the Profession, and to the Public.....	553
Butter, A Plea for More Liberal Use of.....	82	Dispensary Reform in England.....	366
Calculus in an Infant.....	278	Dog, The.....	85
Cancer, An line Injections for Hopeless.....	435	Diuretin, Therapeutic Effect of.....	61
Cancer of Breast, Earliest Symptoms of.....	323	Dried Fruit, Sulphuring or Bleaching of.....	217
Cannabis Indica.....	62		
Carcinoma of the Female Breast, Skin Dimpling in.....	360		
Carcinoma, Stites' Test for.....	106		
Carriage, A New Electrical.....	285		
Case Reporting, The Habit of.....	146		
Cataract, The Simple Extraction of.....	67		

PAGE.		PAGE.	
Drugs, Dosage of .....	33	Gunpowder, Smokeless.....	105
Drugs in Massachusetts, Examination of.	151	Gymnastics for College Girls.....	454
Druggist's War Against Telephone Companies .....	12	Gynæcology, Sacral Resection in.....	38
Drunkenness, Swedish Cure of .....	527	Gynæcology, The Faradic Current in....	393
Dysentery, Treatment of, by Irrigation of Lower Bowels .....	18	Hæmaturia of Early Adult Life in Females.....	457
Ear Case, An.....	327	Hæmatoma of the Vulva following Labor, Three Cases of.....	375
Echinococcus Hominis in Iceland, Explanation of the Cause of the Prevalence of.	551	Hæmoglobinuria .....	289
Eclampsia, Pilocarpine in Puerperal.....	102	Hair Tufts in Man, Function of the....	481
Electrical Executions, Abolition of.....	571	Handwriting, Physicians' .....	97
Elephantiasis Scroti, A Case of.....	221	Harlan, Herbert, M. D.....	6
Emphysema, Complete Subcutaneous.....	459	Harvard Medical School, Words of Cheer from .....	341
Endometritis, Chronic .....	485	Health Board, Chicago Physicians and..	522
England, Cottage Nurses in .....	169	Health Inspectors, Medical Men as.....	284
Eneuresis, Rhus Aromatica in .....	329	Health, Shall I Send My Patient Away for His.....	395
Epidemic, A Strange.....	171	Heart, Suction Power of the.....	184
Epilepsy, Coma and Drowsiness as the Only Sign of.....	303	Herpes Zoster in Children.....	187
Epithelioma, Caustic Potash Injections in	339	Hiccough, Treatment of.....	86
Ether, Hypodermic Injections in Suspected Opium Poisoning.....	349	Hines, W. Frank, M. D.....	456
Ethics, Code of.....	422	Hip Joint, New Treatment of Congenital Dislocation of .....	305
Ethmoid Bone and Frontal Sinus, Disease of the.....	411	Hip Joint Disease, Treatment of.....	150
European Profession As Seen Through American Spectacles.....	327	Hodgdon, A. L., M. D.....	331
Europen .....	64	Howard, Wm. Lee, M. D.....	551
Exalgine in Diseases of Children .....	80	Hydrochlorate, Phenocoll.....	437
Exalgine, Treatment of Chorea by.....	438	Hygiene in Russia.....	103
Eye Practice, the Japanese Hot-Box in .....	388	Hyperidrosis, Treatment of.....	382
Face Presentation, a Difficult.....	439	Hypnotics, Some of the Newer.....	63
Faculty Meeting, The Coming.....	563	Infant Foods Other than Breast Milk.....	425, 450
Faculty, The Semi-Annual Meeting of the, at Rockville.....	99	Infants, Meig's Food for .....	14
Faradization in Incontinence of Urine.....	362	Infants, Thermic Fever in.....	9
Feces, Death from Impaction .....	456	Infants, French Law to Protect.....	447
Female, Appendicitis in the .....	156	Inflammation in Women, Pelvic.....	415
Female Mamma, Clinical Importance of Skin Dimpling in Carcinoma of the .....	309	Influenza ("La Grippe").....	397
Femoral Vein, Wounds of the.....	195	Influenza, Brandy and.....	413
Femur, Report of Case of Chronic Suppuration Osteo-Myelitis of, with Amputation	94	Influenza in England.....	257
Femur, Results of Treatment of Simple Fracture of Shaft of .....	15	Influenza in Europe, Progress of.....	175
Fevers, Continued, of the South .....	81	Influenza, Observations on the Treatment of Epidemic.....	331
Fever, Spotted.....	412	Influenza, Progress of .....	191
Fever, Typhoid, Treatment of by Baths.	365	Influenza, The.....	188
Fibroids, Growth of, After the Menopause	240	Influenza, The Bacillus of .....	18
Florida, a Health Resort .....	100	Influenza, The Brain in.....	417
Forests on Climate, the Influence of .....	427	Influenza, Nervous and Mental Phenomena and Sequelæ of.....	312
Fracture. A New Treatment for.....	148	Influenza, Will the, Return This Winter.	98
Gaither, A. Bradley, M. D.....	333	Influenza, with Nausea and Vomiting....	209
Gardner, W. S.....	71	Inebriate, Management of the Paroxysmal	192
Gall-Stones, Sweet Oil for.....	128	Insomnia, Treatment of, with Drugs.....	238
Gastritis, Chronic .....	382	Intestinal Occlusion, Galvanism in.....	284
Glanders, A Case of .....	394	Intestinal Occlusion, The Constant Electric Current in.....	475
Glottis, Spasm of the.....	184	Iodide of Potassium and Chlorate of Potassium, Incompatibility of .....	40
Goitre, Cataphoric Treatment of, with Iodine .....	10	Iodine in False Croup.....	371
Goitre, Iodoform Injections in.....	13	Iodine, Tincture of, How to Carry in your Satchel.....	141
Gonorrhœa, Systemic Infection in .....	217	Iron in Large Quantities in Anæmia.....	14
Gonorrhœa and Child-Bearing .....	458	Iron Salts, How Disposed of.....	13
Gonorrhœa in the Female.....	84	Jackson, Edward, M. D.....	67
Gout, A Remedy for.....	18	Johnston, Dr. Christopher, Tribute to the Memory of.....	11
Gout and Rheumatism, Electric Cataphoresis for.....	173	Keene, S. A., M. D.....	553
Gouty Eyelids.....	570	Kirkpatrick, A. K., M. D.....	338
		Laryngeal Vertigo or Laryngeal Epilepsy, A Case of .....	501



PAGE.	PAGE.		
La Grippe in Children, Manifestations of. . . . .	503	Pericarditis, Mediastino . . . . .	218
Leper Hospital in Norway, Notes from a. . . . .	211	Perineum, After-Treatment of Repair of. . . . .	194
Leucocyte, The. . . . .	208	Pessary, The Era of the. . . . .	253
Leucoderma Syphiliticum . . . . .	131	Pharmacy, Legitimate. . . . .	60
Light, A New and Powerful . . . . .	368	Pharmaceutical Agent. . . . .	189
Litholapaxy, Peculiar Accident During. . . . .	287	Pharyngitis . . . . .	64
Liver Abscess, Treatment of, by Siphon Drainage. . . . .	416	Phlegmasia Dolens. . . . .	61
Locomotor Ataxia, Trophic and Sensory Disturbances in . . . . .	294	Physicians as Petitioners. . . . .	164
Lysæmia, or Malarial Hæmaturia . . . . .	172	Physiology, Progress in. . . . .	168
Mark Twain in a New Role. . . . .	255	Pichi in Cystitis. . . . .	307
Maryland Physicians as Book Writers. . . . .	123	Piles, Causation and Treatment of. . . . .	479
Maternities, Artificial . . . . .	503	Plaster Jackets, Studies in, Etc. . . . .	441
Medical Education, Stray Thoughts on Protracted . . . . .	340	Plaster Jacket. . . . .	453
Medical Education and the Student's Wants . . . . .	76	Plaster-of-Paris Work, Points in . . . . .	17
Medical Law, The . . . . .	525	Platt, W. B., M. D. . . . .	353
Medical Literary Composition, Brevity in. . . . .	34	Pleural Effusion, Diagnosis of. . . . .	306
Medical Practice, Expectation of Reward in . . . . .	33	Pleurism. . . . .	460
Medical Practice in Japan. . . . .	85	Political Bums, Is Our Health De- partment to Continue an Asylum for. . . . .	502
Medical Practitioners' Protective Alliance; A Warning. . . . .	75	Polypi in the Antrum, Nasal Hydrorrhœa Caused by. . . . .	526
Medical Progress in the States. . . . .	328	Population in France, Decline of. . . . .	472
Medicine, Neglected Field of. . . . .	413	Potassium Nitrate . . . . .	147
Medicine, Notes on History of. . . . .	133	Potassium Permanganate in Rattle-Snake Bites. . . . .	347
Medicine, History of . . . . .	145	Practice, Therapeutic Notes from. . . . .	253
Microbic Pylonephritis, Ascending. . . . .	394	Practical Politics, The Problems of. . . . .	500
Micro-Organisms, Observations of. . . . .	80	Pregnancy, Extra-Uterine, Report of a Case Illustrating the Diagnosis of. . . . .	111
Microscopic Lenses, Recent Improvement in. . . . .	386	Pregnancy, Tait on the Corpus Luteum of. . . . .	350
Migraine, Treatment of. . . . .	42	Pregnancy, Vomiting in. . . . .	372
Miscarriage. . . . .	1	Presbyterian Eye, Ear and Throat Charity Hospital for 1891, Annual Report of. . . . .	433
Montgomery, E. E., M. D. . . . .	1	Preston, Geo. J., M. D. . . . .	295
Morphia Habit, For the. . . . .	191	Price, M., M. D. . . . .	23
Morphia in Pregnant, Parturient and Nursing Women. . . . .	39	Prostate, Inflammation of the. . . . .	65
Mosquito, How to Laugh at the. . . . .	106	Pruritus Ani, Tercum Scordium in. . . . .	347
Mosquito Inoculations, Dr. Finlay's. . . . .	148	Rectum, Potato in. . . . .	37
Myalgia Lumbalis and Lumbar Sprain, Diagnosis Between . . . . .	40	Rectum, Prolapse of the. . . . .	386
Myopia in Schools . . . . .	13	Rectum and Anus, Malformation of the. . . . .	488
Myxœdema . . . . .	102	Reform, Dress. . . . .	412
Nephritis, Etiology of. . . . .	14	Respiration, Artificial, in Cyanosis from Plugging of the Bronchial Tubes. . . . .	461
Nephritis, Latent, in Children. . . . .	104	Respiration, Cheyne-Stokes. . . . .	261
Neuralgia . . . . .	42	Rest Cure and the Cases to which it is Applicable . . . . .	90
Neuralgia, Nerve-Stretching in . . . . .	565	Ringworm . . . . .	17
New Remedies. . . . .	152	Rhinology, Aphorisms in. . . . .	101
Obituary, Donaldson, Professor Francis. 137, 236		Salicylamide . . . . .	36
Obituary, Dr. Thomas B. Evans and Dr. T. Barton Brune. . . . .	65	Saline Fluid, Intra-Venous Injections of. . . . .	393
Œdema of Lungs. . . . .	83	Salol in Infantile Diarrhœa. . . . .	339
Onomatomania. . . . .	304	Salpingitis, Periodic Insanity Associated with . . . . .	360
Opiates, Some Contra-Indications for the use of. . . . .	356	Sanitary Improvement, A Questionable. . . . .	148
Opium Disease, Some New Studies of the . . . . .	419	Sanitation, Petition of the Clinical Society Touching the City. . . . .	160
Opium Giving, The Physician and. . . . .	363	Scarlatina, Notes on. . . . .	193
Opium on the Eye, An Effect of. . . . .	392	Sciatica Neuritis, Local Abstraction of Blood in. . . . .	504
Opium Slaves, Who Make the. . . . .	409, 455	Sea-Air, No Salt in. . . . .	171
Opium, A Substitute Wanted for, in the Pelvic Pains of Women. . . . .	410	Siler, C., M. D. . . . .	367
Orbital Hæmorrhage in Children. . . . .	460	Skin Eruption, Rare Form of . . . . .	370
Ovarian Sarcoma, Two Cases of. . . . .	512	Sleep. . . . .	190
Ovariectomy, Its Use and Abuse. . . . .	193	Slums, Renovation of the. . . . .	257
Ovary, To Operate on the, Without De- stroying the Procreative Function. . . . .	258	Snake-Bite . . . . .	12
Palsy, Epilepsy of Cerebral, in Children . . . . .	569	Sneezing, As Simple as. . . . .	83
Paralysis, Infantile, Treatment of. . . . .	83		
Parturition in the Savage Indian. . . . .	108		
		SOCIETY REPORTS.	
		Baltimore Gynæcological and Obstetrical Society. . . . .	185, 428, 558

PAGE.	PAGE.		
Baltimore Medical Association.....	556, 406	Transfusion, Resuscitation by Peritoneal	564
Baltimore Medical and Surgical Society..	140, 250, 379	Tuberculin, Dr. Koch's.....	42
Clinical Society of Maryland....	161, 228,	Tuberculin and Cantharidin.....	498
Washington County Medical Society.....	360, 469, 494,	Twins, Case of Inter-Partum, Hour-Glass	
Spine, Causes of Lateral Curvature of the.	279	Contraction of.....	479
Spine Diseases, The Roller Bandage for		Typhoid Germ, The.....	392
Pains of.....	59	Typhoid Fever and Salads.....	196
Spine, Fractures and Injuries of the Cervical Region of.....	180	Typhoid Fever, The Hydratic Treatment of.....	280
Spine, Lateral Curvature and Pott's Disease of, The Wood Corset, with Improvements, for the Treatment of.....	265	Typhoid Fever at New York, The Recent Incursion of.....	463
Spine, Traumatic Lesions of the.....	82	Ulcer, Abdominal Section for Perforation by Gastric.....	369
Sponges, Dish-Rag Gourd as a Substitute for.....	283	Ulcer, Perforation of Typhoid.....	567
Sputum, Detection of Tubercle Bacilli in.....	373	Ulcers of Leg, Treatment of Old.....	43
Squint, Modified Operation for.....	36	Umbilicus, Septic Disease of the.....	86
Stirpiculture.....	297	University Extension.....	59
Stomatitis Materna.....	505	University of California, The Graduation Oath of Medical Department.....	147
Strangury, Powdered Nutmeg for.....	146	Urethra, The Bladder and Ureters During Pregnancy, Labor and the Puerperium.....	144
Street, David, M. D.....	289	Urethritis, Treatment of.....	333
Street Cleaning, Boston Physicians and.....	321	Urticaria, Treatment of.....	414
Stricture by Diet, Treatment of.....	527	Uterine Appendages, Ultimate Results of Removal of the.....	170
Stye, Treatment of.....	42	Uterine Displacements, On the Principles of the Treatment of.....	223
Subscriber's, Private Suggestion to.....	560	Uterine Fibroids, Electricity in the Treatment of.....	261
Sulphonal, Untoward Effects of.....	307	Uterine Hemorrhage, The Electric Current for.....	215
Surgeon, U. S. Army.....	369	Uterine Safety Tube, The Atmospheric Tractor and.....	279
Surgeon-General's Office, Danger to the Library of the.....	473	Uterus, Case of Inversion of a Non-Puerperal.....	248
Surgery, After-Treatment in.....	438	Vaccination, Ancient Hindu.....	459
Surgical Operation, Relation of Albuminuria to.....	216	Vaccination, The Protests Against.....	252
Surgery, Some Considerations Concerning Antiseptic.....	45	Vaginal Secretion, Doederlein's Work on.....	558
Syphilis, Malignant.....	372	Valedictory.....	9
Syphilitic Ulcerations.....	19	Vegetations, Post-Nasal, Occasional Hardness of Hearing Sometimes the Only Symptom of.....	178
Syphilitics, Shall We Operate on.....	390	Vegetables, Medicinal Properties of.....	107
Tape-Worm, For.....	415	Version, Cephalic.....	77
Tea, Beef.....	210	Version, Cephalic, After the Beginning of Labor.....	71
Teeth, Artificial, From a Hygienic Point.....	350	Vertebrae, Sixth or Seventh Cervical, Report of a Probable Case of Function of the.....	244
Teeth, Care of the Milk and Permanent..	78	Vesiculae Seminales, Infective Inflammation of the.....	481
Teeth, Decay of the, in Young Mothers..	149	Virchow's Observations on Old Athenian Skulls.....	19
Teeth, Eruption of, and General Symptoms of Deciduous.....	211	Virchow, Prof. Rudolph.....	29
Telephone, Substitute for the.....	32	Vomiting of Children, Lavage in Persistent	344
Temperance Hospital, Ether Stimulant at.....	479	Vomiting of Pregnancy, Some Mooted Points Concerning the.....	245
Tendons, Grafts Introduced Between the Widely Separated Ends of Divided.....	320	Warts, Fowler's Solution for the Cure of..	39
Tetanus Bacillus.....	389	Water-Bed as a Means of Effecting the Temperature of the Body.....	459
Thanksgiving.....	122	Werner, M. D., Marie B.....	356
Therapeutic Testing.....	143	Whooping Cough, Essential Oil Cypress in	18
Therapeutics, A Dangerous Tendency in.....	383	Whooping Cough and Vaccination.....	19
Therapeutics, What Modern, May Lead to.....	37	Whooping Cough, Treatment of.....	195
Thuya in Hydrocele and Hemorrhoids..	18	Whooping Cough, Climatic Treatment of.....	103
Tinnitus Aurium, Some Cases of, Treated by Paracentesis.....	6	Wickersheimer Preservative Fluid.....	39
Tissues, Are Micro-Organisms Normally Present in the.....	300	Window Panes, Ventilation by Perforated	527
Tobacco Vapor, Toxic Effect of.....	7	Wood Ointment, the Active Principle of	37
Tobacco Harmless, Attempt to Render.....	207	Wound, Gunshot, With Use of the Electric Probe.....	338
Toe, Painful.....	568	Wound Infection.....	153
Tongue, The Black Hairy.....	348		
Trachoma, Treatment of, With Special Reference to the Method of "Expression" and to the Use of Knapp's Roller Forceps.....	402		
Tubercle Bacillus, The Prognostic Significance of the.....	105		

# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

Miscarriage. By E. E. Montgomery, M. D., of Philadelphia. . . . . 1

Some Cases of Tinnitus Aurium Treated by Paracentesis. By Herbert Harlan, A.M., M.D. . . . . 6

### EDITORIAL.

Valedictory. . . . . 9

Heat Stroke (Thermic Fever) in Infants. . . . . 9

The Cataphoretic Treatment of Goitre with Iodine. . . . . 10

Tribute to the Memory of Dr. Christopher Johnston. . . . . 11

### MEDICAL PROGRESS.

Snake Bite.—The Druggists' War Against Telephone Companies.—How are Iron Salts Disposed of?—Iodoform Injections in Goitre.—Myopia in Schools.—Etiology of Nephritis.—Icton in Large Quantity in Anæmia.—Meigs' Food for Infants.—Corns Under the Nails.—On the Results of the Treatment of Simple Fracture of Shaft of the Femur.—The Diagnosis of Tumors of the Bladder.—Points in Plaster of Paris Work.—Diphtheria.—Ringworm.—Incompatibles of Antipyrine.—The Bacillus of Influenza.—A Gout Remedy.—Treatment of Dysentery by Irrigation of the Lower Bowels.—Thuya in Hydrocele and Hemorrhoids.—Essential Oil of Cypress in Whooping Cough.—A New Use for Aristol.—Syphilitic Ulcerations.—Whooping-Cough and Vaccination.—Virchow's Observations on Old Athenian Skulls. . . . . 12

### MEDICAL ITEMS.

. . . . . 20

## Original Articles.

### MISCARRIAGE.\*

BY E. E. MONTGOMERY, M. D.,

Professor of Obstetrics and Gynecology in the Medico-Chirurgical College, and Obstetrician to the Philadelphia Hospital.

*Gentlemen:* The patient I bring before you to-day is a colored woman, twenty-two years of age, married, who has had several brothers and sisters who died in childhood; she had the usual diseases of childhood, and last winter had rheumatism, which confined her to bed three weeks. Menstruation has been regular but painful. She was married at nineteen, has had two full-term children, one living a few hours, the second a year. On September 26, she fell downstairs; the next morning she suffered from pain in the back. She had not menstruated since April last, which would make her about five months pregnant. She had a miscarriage, during which she lost a great deal of blood. Upon admission to the hospital, her cervix was found sufficiently open to admit the introduction of two fingers and the cavity of the uterus was filled with a pliable mass. After its removal, her temperature ran up to 101½; the abdomen became swollen and quite tender, although there was no other indication of septic infection. Her temperature at present is slightly above normal and she is progressing as well as could be expected. Upon her admission to the house, Dr. Janney examined her and found the uterus filled with a mass, and very properly proceeded to its removal. Her temperature was but slightly above normal, but it increased afterward and continued higher for a few days. The presence of the elevation of temperature and its exaggeration subsequent to the removal of the mass, would

\*Clinical Lecture delivered at Philadelphia Hospital, Oct. 7th, 1891.

lead us to believe, notwithstanding the fact that the placenta had not become putrid, that it had undergone changes sufficient to produce a condition of sapremia, which caused the exaggerated symptoms. We will use this patient as a text for the discussion of the subject of miscarriage. By miscarriage is meant any interruption of pregnancy previous to the period of viability of the fœtus. Interruption of pregnancy subsequent to this period is that which is known as premature labor. As the fœtus rarely lives when born before the seventh month, any interruption previous to this period, then, is properly designated as miscarriage. It may take place at any period, although it probably occurs more frequently at or near the third month. The occurrence of miscarriage may be divided into three periods, according to the development of the fœtus. First, ovular miscarriage, which comprises those interruptions which take place during the first three or four weeks of gestation; second, embryonic, which may take place any time between the end of the first and the end of the third month; third, foetal, where it occurs between the fourth and the seventh. These divisions are of importance for the reason that we cannot but recognize that a development of the ovum and of the uterus is so manifestly different at the different periods that they must exert an influence upon the readiness with which the product is expelled. During the first month, the ovum is engrafted in the uterine mucous membrane, which swells about it, and constitutes the decidua reflexa. It is already composed of its two membranes, the amnion and the chorion, while the uterine mucous membrane presents the parietal decidua, decidua reflexa, and that between the uterus and the ovum. When removed from the decidua, the ovum looks like a small body, roughened by the projection of a number of appendages, one longer than the others, at the center of which is found the amnion, containing the microscopic embryo. In the second stage, we have the fœtus, with its three membranes, the chorion, amnion and allantois, with the development of the placenta. The uterine placental adhesions become so firm during this period that it is oftentimes necessary to forcibly remove the placenta. The uterus is unprepared for the evacuation of its contents and accomplishes it with difficulty. After the fourth month the condition of miscarriage is labor upon a small scale. The separation is more readily accomplished, and usually with less difficulty and danger to the patient. It is difficult to determine at which period miscarriage is most likely to occur; the statistics of large hospitals is of but little advantage in this respect, as the class of cases treated therein are not those in which the accident is most likely to occur. We cannot depend upon the experience of physicians in private practice, for the reason that it is the habit of but few to keep accurate account of the occurrence of such cases, with the causes leading thereto. It is more likely to occur, however, at the would-be menstrual periods, as the cyclical congestion produced is likely to be continued even after the establishment of pregnancy, and the distention of the vessels may lead to the separation and expulsion of the contents of the uterus.

The causes of miscarriage may be dependent upon various conditions; these conditions may be inherent in the father, in the mother, in the ovum, or be the result of criminal abortion or of external violence. Thus it may result from the father, owing to his youth, immature development or enfeebled state of health that may render him likely to procreate enfeebled offspring. Of diseased conditions, syphilis in the father is one of the most frequent causes for premature interruption of labor. This may result in loss of the fœtus without infection of the mother. Syphilitic disease in the mother is a prolific source for

the interruption of gestation, and in cases in which interruption has been frequent without other uterine cause being present should always be suspected. Inflammatory conditions of the uterus, especially of the mucous membrane, are likely to result from conditions that preclude the development of healthy and normal decidua, so that the embryo, as it increases in size, receives deficient nourishment and is likely to end prematurely. In some cases there is an irritable condition of the uterus in which slight causes may be promotive of the occurrence of the condition. Laceration of the cervix is probably one of the most frequent causes of its occurrence. The congestion and inflammation of the uterine mucous membrane which results from this lesion, brings about the defective development of the uterine portion of the foetal sac. The recurrence of criminal abortion and the methods used for producing it are subjects upon whose consideration we need not enter. External violence, shock, fright, are causes which, not unfrequently, in irritable uteri, or in nervous women, may lead to the premature emptying of the organ. It is true, however, that there are cases in which severe blows and falls have no influence whatever upon the progress of gestation. These are cases in which the genital organs are in a healthy condition.

You will ask what are the symptoms that should lead one to fear the occurrence of miscarriage. The symptoms are, sensation of weight and distress in the pelvis, recurring pains of an intermittent, labor-like character, and the discharge of blood. The occurrence of bleeding during gestation is always looked upon as a threatening symptom, although it is well to remember that there are cases in which menstruation occurs regularly during the entire period of gestation; others in which it continues for the first three months. Indeed, I have seen cases in which the advent of gestation was accompanied with an increase of menstrual flow amounting to hæmorrhage, during the first three months. In the conditions occasioned by catarrhal inflammation of the cervix with dilated vessels, which, under the increasing congestion of pregnancy, rupture, hæmorrhage is produced. It is well to remember that women are more likely to abort at the menstrual periods than during the intervals, and those patients who have a tendency to miscarriage should be directed to remain perfectly quiet at this time and avoid anything which is likely to increase the irritability of the uterus. In determining whether a miscarriage has or is about to occur, one of the first things is to determine whether or not the woman is pregnant. Of course the symptoms presented previously would lead us to an inference upon this subject. One of the first symptoms of pregnancy is cessation of the menstruation, but the menses may be interrupted from a variety of causes other than the occurrence of pregnancy.

In the earlier months of pregnancy, Hegar has pointed out that the uterus, under the influence of pregnancy, increases in its anterior posterior diameter out of proportion to the increase laterally, and that this increase takes place in the body without enlargement of the cervix, giving rise to a jug-shaped enlargement of the body of the organ. This symptom may be recognized as early as the second month of pregnancy, and in those cases in which the abdominal walls are sufficiently thin to admit of ready palpation, it may be considered as a positive indication of pregnancy. It is true, the uterus may be enlarged as the result of chronic inflammation, and, in such cases, the enlargement is more uniform, involving all diameters of the uterus, and the cervix also partakes of it. Next to this, the only positive and absolute indication of pregnancy is the determination of the foetal heart sounds. These, however, are not determined prior to the fourth month.

You may be at a loss to determine whether a threatened abortion has resulted in the destruction of the vitality of the embryo. Ordinarily, when the fœtus is dead it is thrown off within a few days or a week, and at most, but in some cases the uterus retains the fetal envelopes within it, and may do so for a number of months. I remember, some years ago, a young lady came to me with every indication of being pregnant about two months, and complained of having slight flow. She was placed at rest, every measure taken to prevent the occurrence of the miscarriage, and the unpleasant symptoms ceased. At the end of three months more, she was again taken with symptoms of a similar character, and it was found that the abdomen had not increased in size. Upon examination, the uterus was found dilated, and a small sac was expelled. Upon opening this, its only contents were a short cord, and dirty colored serum. This was a patient in whom the symptoms had led to the loss of the vitality of the ovum, before the envelopes had been sufficiently attached to the uterus to derive from it the necessary nutrition to keep them from undergoing decomposition. The slightly enveloped embryo had become macerated and liquefied. I have known of other cases in which the fœtus had been retained for a month or two months after death before it was evacuated. In such cases, where there is no doubt of the vitality of the embryo, it is well that the patient's subsequent progress should be carefully watched, to determine the indications of further development.

The treatment of miscarriage may be divided into two heads: the prophylactic and the curative. The prophylactic treatment consists in placing the patient under the best possible conditions for the promotion of her general nutrition and furthering that of the developing embryo. All sources of irritation should be avoided, marital relations should be discontinued, and where any discrasia exists, she should be placed under proper treatment for recovery. In cases of a severe uterine inflammation, prophylactic measures should be taken before the development of pregnancy. An opportunity for becoming pregnant should be avoided until a healthy condition of the tissues has been secured. In syphilitic conditions the patient should be placed under a course of anti-syphilitic treatment and this should be continued even after the development of pregnancy. In patients in a low state of health the chlorate of potash with tr. ferri chlor. continued for a length of time will be found of great benefit. Where a miscarriage is threatened, the patient should be at once placed in bed, be kept perfectly quiet, the bowels should be regulated, nourishing and easily digested food administered, and irritation of the uterus decreased by small doses of opium. This may be given in the form of a tincture, or by suppositories. If hæmorrhage occurs, it may be arrested by the administration of ergot with viburnum prunifolium.

Where miscarriage is imminent, the hæmorrhage may be a very serious symptom, and if neglected be the cause of the death of the patient. It is usually recommended to administer ergot freely, giving a teaspoonful of the fluid extract every one, two, or three hours, until the uterus contracts (the cervix as well as the body of the uterus), and practically imprisons the ovum within. The better plan of procedure in the earlier months is to thoroughly tampon the vagina—not only the vagina, but the cavity of the cervix as well. In introducing the tampon, the patient should be placed in the semi-prone position with the Sims speculum in use. The vagina should be thoroughly sponged out with an antiseptic solution and then the cavity of the cervix packed with iodoform gauze. After packing the cervix, the vagina may be packed as well, introducing the tampon firmly in the posterior fornix and around the fundus of the vagina. In this way the tampon not only controls hæmorrhage, but by its presence in the cervix promotes

the dilatation of the organ. In the non-pregnant uterus, by this method of procedure the organ can be so dilated that its entire cavity can be subjected to inspection.

In cases in which pregnancy is advanced, the tampon of the uterus, together with the administration of ergot, will be an effective method of securing the early expulsion of the contents of the uterus. The most favorable form in which miscarriage can occur is where the entire ovum or embryo in its envelopes, is expelled. Unfortunately, this is not usually the case, but the foetus escapes from the ruptured sac and the placenta and envelopes remain. This may undergo several processes; it may be retained without putrid change taking place; second, it may be retained and become decomposed; third, it may be absorbed. As the placenta does not undergo putrid change, there has been a very great diversity of opinion as to how its retention should be treated. Some advise delay, giving nature an opportunity to summon her forces to empty the uterus. Others advocate prompt measures for completion of the evacuation.

While it is true that the contents of the uterus do not always undergo putrid change and may be thrown off without producing any deleterious effect upon the healthy individual, yet the serious results when it is permitted to remain are such as to demand, in our judgment, the prompt removal of the retained envelopes in every case. It is so difficult to limit the septic change and the absorption of the products of decomposition, that it seems to us that this advice is wise. The mucous membrane of the tubes being continuous with that of the uterus, may be very soon affected by the extension of the inflammation and develop a condition from which the patient is only relieved by a sacrificial operation. In every case in which there is indication of decomposition occurring, as shown by offensive lochia, the contents should be immediately removed. The condition admits of no delay, and the uterus should not only be emptied, but should be thoroughly irrigated with a chemical disinfectant, such as the sublimate, or the peroxide of hydrogen, and the subsequent discharges from the uterus effected by proper drainage. A very efficient method of drainage is by the introduction of a twist of iodoform gauze projected to the fundus of the uterus, permitting it to remain in for twenty-four hours. It keeps the surfaces of the uterus apart, facilitates drainage through capillary action, and promotes serous effusion from the walls of the uterus which decreases the probability of septic absorption. The danger in the majority of cases, and the cause of elevation of temperature in this individual, after the thorough cleansing of the uterine cavity given her by the doctor, is undoubtedly due to defective drainage. With the surfaces of the uterus lying in contact, the exfoliated debris imprisoned in the meshes undergoes change from infectious material, probably already within the uterus, and its products are readily absorbed.

That disease may extend from the uterus to the appendages in a very short time, a case which came under my own experience within the last year abundantly demonstrates. A woman was seen in consultation, on account of a miscarriage which had been brought on a week before. My judgment was desired as to the advisability of emptying the uterus of the remaining vestiges of the placenta. Upon examination, I found the uterus pushed upward by an accumulation in the posterior cul-de-sac, and advised not only emptying the uterus but opening the abdomen. The afternoon of the same day the patient was placed under an anæsthetic; the vagina thoroughly irrigated and sponged out, the uterus dilated, and the decomposing placenta removed. The

cavity of the uterus was irrigated and then, after carefully washing our hands, the abdomen was opened, when half a pint of pus was removed from the posterior cul-de-sac, and the uterine appendages excised. The patient recovered promptly, without an unpleasant symptom. Had we resorted to either one of these operative procedures to the neglect of the other, the result would have been fatal.

### SOME CASES OF TINNITUS AURIUM TREATED BY PARACENTESIS.\*

BY HERBERT HARLAN, A. M., M. D.

What is commonly called catarrhal deafness, or what is better designated chronic non-suppurative inflammation of the middle ear, is unquestionably one of the most intractable diseases we are called on to treat.

The onset is insidious and a large part of the hearing is often gone before the patient is aware that he does not hear as well as other people. When he makes this discovery and is confirmed in it by his friends, he usually sees his family physician, an aurist or two, then a charlatan or two, and then settles down into the belief that he is deaf and ear doctors can do very little good. With the above diagnosis correctly made, it is my opinion, also, that the prognosis is about right. But on that very account it is exceedingly important that acute trouble of the middle ear should not be neglected and allowed to go on without hinderance to the chronic form.

Chronic catarrhal deafness, for which so little can be done, frequently has tinnitus as the most annoying symptom, and the aurist, in spite of all skill, has too often to acknowledge inability to cope even with this one element of the disease. In most cases of catarrhal deafness there is more or less buzzing in the ears. This is generally slight, but may be a serious cause of discomfort and in a few seemingly well authenticated cases has driven the sufferers to suicide as the only chance for relief from their torment. I recall three of my own cases where the patients stoutly asserted they should certainly go crazy if they did not obtain relief. One of these still suffers and is sane. The other two were from a distance and I do not know the subsequent history.

The character of noises heard is various, and probably is different in intensity, but the description of the sounds seems to depend a good deal on the station in life. It has been suggested that people from the country usually describe sounds with which country people are more or less familiar, and the tinnitus sounds to them like the buzzing of bees or the roar of a waterfall, while city people describe the noises as like that made by a vessel blowing off steam, or like the continuous rattle and rumble of vehicles over cobble stones.

Occasionally the sounds take a musical turn—generally discordant music, it is true—but I saw one case in a young lady who said she was constantly hearing the most delightful musical sounds.

In the present state of medical science most of these cases are incurable. A small percentage can be cured, and a somewhat large percentage can be benefited temporarily by some special line of treatment, even after all others have failed. Five years ago, in some particularly obstinate cases, I determined to try the old remedy of paracentesis which for a while was much vaunted and then fell into disfavor. I think it evident that the measure should not be resorted to indiscrimi-

\*Read at the 729th meeting of the Medical and Surgical Society of Baltimore, October 8th, 1891.



nately. By means of hearing tests the seat of disease can be located with a fair degree of certainty, and if, for example, the hearing is nearly perfect, the membrana-tympani in good condition and the eustachian tubes readily opened, a mere cutting of the drum, thus putting a normal organ in a very abnormal condition, could certainly not be expected to remedy a buzzing due to some alteration in some other region of the very complicated organ of hearing.

Again, if tinnitus be associated with very great impairment of hearing, and this deafness by subjective and objective examination is evidently due to disease of the labyrinth, the tinnitus is probably due to the same causes, and the prognosis for the tinnitus must be equally as unfavorable as that for the deafness.

But, given a case where the chief disease is in the sound conducting apparatus, where the tuning fork is heard most distinctly when in contact with the bones of the skull, where the eustachian tubes are impervious or only opened with difficulty and by the aid of a catheter, where inspection shows a thickened and sunken drum head, and so where the chief disease is in the middle ear—in these cases it is reasonable to hope there may be some improvement from paracentesis. The rationale I think is this: By opening the drum, equilibrium between the middle ear and the outer air is established and if the incisions are free and more or less frequent the cicatrices, in contracting, draw the drum tense and so put it in more nearly the normal condition.

The notes of the few cases which I desire to present to the society are, I know, very incomplete and the results not at all brilliant, but those of us who are called on to treat tinnitus aurium know that it is a good deed to help even a few of these unfortunates.

CASE 1.—Mr. F. æt. 50, Sept. 5th, 1886; tinnitus and deafness. Terrible roaring in both ears; noise in the right H. R. and L.  $\frac{2}{3}$ . Fork better on mastoid. Cocaine solution was put in the ear and after ten minutes a downward incision was made on each side of the long head of the malleus, the incisions coming together and making a V-shaped opening. The pain was not great and was only momentary. A plug of absorbent cotton was put in the external auditory meatus.

Sept. 6th. The condition as regards roaring and deafness the same. A blunt hook was then used to open again the incision, and being passed behind the handle of the malleus, this was pulled away from the posterior wall. Sept. 8th. Patient says he hears better and there is much less roaring. Sept. 10th. After relief for two days, roaring returned. Hearing the same; same operation as before was again performed, and patient was not again seen until Oct. 6th, nearly a month later, when he reported that for two weeks he had been quite comfortable, but that now again he was in the same condition as at first, and he asked to have the operation performed again. At this visit some cerumen was found in the right meatus. This was washed out, and again two free incisions were made in the right drum. Oct. 7th, ear pained a little during the night, but the roaring is much less.

Ten days later, on the 17th, which is the last date of my notes of the case, patient stated that the hearing since the last operation had been better. By my test it was the same as at first. He said the noise was then only a slight buzzing, and that he could stand very well.

CASE 2.—John H., æt. 65, Sept. 3rd. Deaf many years, constant noises in head. Cannot hear a watch at all, and only loud voice. Tuning fork test heard on contact over mastoid and in meatus, but not well anywhere. L.M.T. perforated under cocaine. Sept. 4, a little better. Sept. 6, patient reports that he was better until last night, when he was worse than ever. Sept. 8th, condition the

same. Left M. T. perforated and the eustachian tube opened by aid of catheter. On the 9th and 10th, chloroform vapor was blown into the ear through a eustachian catheter with but little effect, and on Oct. 1st I noted that the incisions of the drum had healed perfectly and the original condition was unchanged.

It is likely that the internal as well as the middle ear was diseased in this case.

CASE 3.—Mrs. B. æt. 42, Sept. 3rd. Deafness in both ears, H. R.  $\frac{c}{24}$ ; constant noises; fork better held near ear than when in contact. Both tubes opened by Politzer bag. As the two ears were apparently the same, I made two perforations in the right drum. On the 7th, condition same. Blood clots over incision. These were torn away and the ears forcibly dilated with the air bag. On the 10th, the drum had healed and she reported that she could now hear the clock tick at home with the right ear, which she could not do before and that the noises were not now troublesome. H. R.  $\frac{1}{24}$  L.  $\frac{c}{24}$ .

CASE 10.—George P., æt. 33, Oct. 1st. Deaf in both ears a long time. H. R.  $\frac{c}{24}$  H. L. Fork only on mastoid. Left ear has been buzzing like escaping steam for six years, worse of late; does not mind the deafness if something can be done for the noise. Perforations were made in the drum on each side. Oct. 3rd, noises less, and thinks he hears better. H. as above. Oct. 6th, perforation healed, buzzing less, though there is still some. M. T. again cut and Politzer bag used.

November 1st. Patient has been coming every two or three days to have air bag used, and says he is being cured and that the noises do not now trouble him, and that he hears much better. By my tests the hearing is about the same, H. R.  $\frac{c}{24}$  H. L. Fork on mastoid, though he seems to hear the voice fairly well.

CASE 5.—R. W. Y., æt. 25, from Dorchester County, Sept. 6th, deafness and tinnitus. H. R.  $\frac{4}{24}$  H. L.  $\frac{1}{24}$ . Perforations were made in the left drum; Politzer. Oct. 12th, when patient again reported, said the noise was about the same but the hearing was better, and I found it to be so. H. R.  $\frac{8}{24}$  L.  $\frac{4}{24}$ .

CASE 6.—Jennie M., æt. 30, Oct. 20, deafness and noise in the right ear three months. Noise so troublesome at times that she thinks she will go crazy. Sometimes it makes her very nervous. Cannot sleep on account of it. Sounds like a locomotive blowing off steam. First appeared after confinement. There was a discharge from the ear for three weeks. Now M. T. thick, white and depressed. H. R.  $\frac{2}{24}$  L.  $\frac{2}{24}$ . Cut R. M. T. under cocaine. Oct. 22nd, less noise. Noise still constant, but not so loud. H. reduced to  $\frac{1}{24}$  R. Oct. 30th, a great deal better. Noise now only troublesome while eating; H.  $\frac{3}{24}$ . Nov. 11th, says she hears better, less noise and at times no noise at all. 15th, condition same; made three openings in M. T. under cocaine. Nov. 18th, says she is a great deal better. Little or no noise and hears much better. Watch, however, only  $\frac{3}{24}$  each.

I have brief notes, which are even more imperfect than these I have read, of five or six other cases treated in 1886, but they are too incomplete to be of any value whatever. Since that year I have been treating obstinate tinnitus by paracentesis, sometimes with partial success and generally with failure, but I have made no notes.

To sum up: Of the six cases, four were benefited, two of them for at least one month. In one, the hearing was improved, the tinnitus remaining the same. One was not benefited and this one by the tuning fork tests had disease of the internal ear.

A statute of Henry VII ordains that that the healing art shall be limited to those persons that be profound, discreet, grandly learned, and deeply studied in physic.

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BALTIMORE, OCTOBER 31, 1891.

**Editorial.****VALEDICTORY.**

In taking leave of the readers of the MARYLAND MEDICAL JOURNAL, as the editor, it is fitting that I should say a word in explanation. When I assumed charge, on the first of January last, it was with the distinct understanding that I should be allowed to lay down my office whenever I thought proper. The proper time has now arrived. The pressure of other duties makes it impossible that I should devote a sufficient portion of my time to the work of the JOURNAL to do myself and it justice. I have tried, and with some success, to manage the work in such way as to maintain and improve those cordial relations which should exist between a medical journal and its immediate public, and I wish to return grateful thanks to the many who have aided and encouraged me in my work. I leave the JOURNAL with the best wishes for its prosperity and success, and I do it the more willingly since my successor in the office of editor is so well fitted to take the reins into his own hands. He has, for some time, been connected with the editorial department, and I have been indebted to him for many of the ablest editorials which have appeared in our columns. I therefore take especial pleasure in commending him most warmly to the subscribers and assuring them that there need be no fear that, in his hands, their interest will suffer.

J. EDWIN MICHAEL, M. D.

**HEAT STROKE (THERMIC FEVER) IN INFANTS.**

In the summer months many adults in this community are prostrated by the heat, or, perhaps, even affected by that severe form of heat stroke known as thermic fever. In view of the grater sensitiveness of the nervous system in infants and the frequency of disorders ascribed to the influence of the hot weather, one would expect that cases of heat stroke in infants would be frequently observed by

practitioners. Yet a search through the literature of pædiatrics would show that this subject has received little or no attention at the hand of writers. The familiar text-books on diseases of children do not make any allusion at all to it as a distinct disease. Yet, from logical reasoning, it is quite certain that heat stroke must very frequently occur in infants, and that it will some day be isolated and separately discussed in the text-books.

These cases of heat fever must have been ascribed either to "brain disease" or to acute digestive trouble. In the opinion of the writer, sudden attacks of cholera infantum (those so wonderfully benefited by quick removal to the country or a trip on the water), are probably all, or nearly all, due to heat stroke.

It is with great interest that we read an article upon this subject, by Dr. Illo-way, of Cincinnati, in the *Cincinnati Medical News*, Sept., 1891. In this he relates at length three cases which he believes to represent true heat stroke.

In the *first* case, a female child one year old, breast-nursed, of good size, and in good flesh, was suddenly seized the last day of August with vomiting and diarrhœa. "Neutral mixture" (liq. potass. citral.?), was administered in teaspoonful doses, with tr. opii. gtt.  $\frac{3}{4}$  every two hours, till about 8 doses were taken. Next morning she was found with very feeble pulse, gasping and shallow respiration, muscles of jaw firmly contracted, face purplish and body very hot. Ice was placed on the head and mustard on the feet, and a few grains of chloral were given in broken doses, a little whiskey being also administered. At 3 P. M., temperature (axilla) was 106°, and patient was unconscious. She was placed in a hot bath with ice to the head. As this did little good the child was now wrapped in a sheet, wrung out in cold cistern water (70°), every ten minutes. Recovery immediately set in.

The *second* patient, a baby ten months old, was seized in June with vomiting and purging and quickly passed into a state of stupor, with heat of head and axillary temperature from 104° to 105°.

The cold wet pack was used with immediate benefit, and the child quickly recovered.

In the *third* instance, a male child one year old, was, during a spell of very hot weather, taken with vomiting, heat of head and axillary temperature of 103°. No medicine was given, but cloths wet with ice water to the head soon wrought a cure.

That these cases were not cases of primary indigestion is proven by the immediate relief of the digestive troubles on application of the cold cloths.

The whole article is well worth reading.

#### THE CATAPHORETIC TREATMENT OF GOITRE WITH IODINE.

The power of iodine to cure certain cases of goitre when injected into the tumor is well known. But cases are recorded in which such injections have produced very disastrous results.

It was some time ago shown that solutions of drugs are very quickly absorbed

by the unbroken skin, if a current of electricity is at the same time passed through the part.

Dr. Hunter McGuire reports (*Nashville Jour. Med. and Surg.*, October, 1891) that he has in this way applied tincture of iodine with great success in the treatment of goitre. Having in his possession a cup-shaped electrode, which he had used for the application of cocaine by the aid of the galvanic current to the skin, he determined to use this electrode for the treatment of an old, bilateral, very large and hard goitre which seriously interfered with respiration, and had for four years steadily increased, in spite of the faithful use of iodine and biniodide of mercury externally, and iodide of potash, iron and mercury internally. It was accompanied by palpitations, giddiness and vertigo, but there was no protrusion of the eyes to suggest exophthalmic goitre. A piece of absorbent cotton was dipped in water and squeezed dry. This was placed in the cup-shaped electrode, ten or fifteen drops of tincture of iodine were placed upon it, and the electrode was laid upon the most prominent part of the goitre, the *negative* electrode being applied to the back of the neck. A constant current of the strength of six or eight milliamperes was then allowed to pass for ten minutes. When the electrode was removed the cotton was simply stained with the iodine, but most of the iodine had disappeared. The patient said the taste of iodine which she perceived during and after the sitting was the most disagreeable part of the treatment. The application was repeated in the same way daily for three weeks. The tumor became gradually smaller and harder. After a month's absence, during which it continued to decrease, the patient returned and took the treatment again daily for three weeks. In this way the tumor was reduced to one-fifth its original size, and, although it could not be further diminished, all unpleasant symptoms vanished.

Two other chronic goitres behaved in the same way.

In four recent hypertrophic goitres in young women, the enlargement rapidly subsided under this treatment.

Dr. McGuire states that prolonged application of iodine in this way will cause a blister. He is having an electrode constructed for similar treatment of hypertrophied tonsils. He thinks that if drugs can in this way be made to penetrate deeply into the tissues, the method may eventually be used for the cure of cancers.

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#### TRIBUTE TO THE MEMORY OF DR. CHRISTOPHER JOHNSTON.

A special meeting of the Medical and Chirurgical Faculty of Maryland was held last Saturday to take action in regard to the death of its late president. After the drawing up of suitable resolutions of respect and regret, many of the physicians and surgeons present endeavored to express in words their appreciation of the character of Dr. Johnston, and of the loss which the Profession of Baltimore had sustained in his decease.

The early promise which he gave of future greatness was dwelt upon by those

who had been his class-mates in college and hospital. His peculiar interest in the scientific side of medicine and surgery was mentioned by his fellow-professors. His loyalty to the truth and to the code of ethics, and his uniform courtesy to those who had occasion to consult with him were gratefully remembered. His kind helpfulness toward certain of his fellow-physicians in time of domestic trouble was related with deep emotion by those who had experienced it. His skill in languages, his dexterity in microscopic work, his literary and artistic culture and his deep interest in the growth of the Johns Hopkins University, to which he made many valuable donations of specimens, were briefly recounted. Nor was his adherence to and practice of the principles and precepts of the christian religion forgotten.

The President of the Faculty, Dr. Welch, felt constrained to comment upon the singular impress which Dr. Johnston had left, not only upon his profession, but also upon the hearts of his associates.

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### Medical Progress.

#### SNAKE BITE.

Dr. Todd writes (*Med. Brief*): I was called some time ago to see a little girl who had been bitten by a large copperhead snake. Found hand and arm very much swollen and of a dark purplish color, suffering severe pain in hand and arm. I immediately made an incision at the point of the bite and had a cloth saturated with urine and applied to hand and arm as far up as elbow, ordered two tablespoonfuls of alcohol well diluted with water every twenty or thirty minutes, until it began to have an effect; also ordered cloths wet with urine occasionally.

Called next day, found the patient much better, swelling reduced; patient said she got easy in twenty minutes after the application of urine. The patient is now well.

I think urine is a specific for snake bites.

The little girl's mother was very much surprised at the quick recovery of the child, as she was bitten once by the same kind of snake and had two doctors, and was very sick for three months and suffered severe pain for several days.

I have used urine for stings of insects with good effects.

Query:—If the patient is short of urine at the time, is it the doctor's duty to supply it?

#### THE DRUGGISTS' WAR AGAINST TELEPHONE COMPANIES.

The druggist is in the way of knowing by sad experience the abuse of the telephone system. The companies controlling this system, with short-sighted policy, endeavor to make of a great public convenience a grasping monopoly. The druggists of Chicago recently appealed to the Illinois legislature to enact a law regulating telephone rates to a more reasonable standard, and the Baltimore druggists have now taken the lead in a fight against this monopoly, being joined therein by the members of many other business organizations.

It is stated it is likely that at the present time the telephone exchange of Baltimore is not overburdened with business, although the managers present a very brazen front and claim they are having plenty to do. Quiet organization and

holding together has accomplished a defeat that will lead to the establishment of a new company at more reasonable rates, or perhaps after the leaders of the present company come to sound sense they may wish to seek their former patrons with the "olive branch."

This is a cause worthy the earnest and aggressive support of all trades. The American people have the reputation of bearing in silence the most unreasonable impositions, but, like the proverbial worm, when roused to united action, can turn on the oppressor and so form public opinion and control legislative action as to remedy the abuses of unjust and unscrupulous monopolies.

If current rumors are reliable, it is highly probable that one of the chief of these Telephone Co.'s will meet its Waterloo in a contest with a rival, The Western Union Telegraph Co., and when Greek meets Greek, or Monopoly Monopoly, then will come the tug of war, and the contestants may in their battle so disclose the unjust exactions of each, as to lead the people to appeal to Uncle Sam to assume himself the settlement of the dispute, by adding to the postal service the management of the telephone and telegraph service—a consummation devoutly to be wished.—*Bulletin of Pharmacy.*

#### HOW ARE IRON SALTS DISPOSED OF?

According to *Merck's Bulletin*, Dr. Jacoby reports in the *Archiv f. Exper. Patholog. und Pharmakolog.* that in recent experiments upon animals he found that the iron salts, when injected into the blood, are eliminated in a few hours to but a very small extent (about ten per cent.), with the urine, intestinal secretions, and bile; the greater part (about 50 per cent.), however, is deposited in the liver, and the remainder in other organs (spleen, kidneys, walls of the intestines). This deposition is ended in 2-3 hours, after which the blood is free from the metal introduced.

#### IODIFORM INJECTIONS IN GOITRE.

Dr. Kapper, an Austrian military surgeon, has employed in fifteen cases, with invariable success, Moseitig's plan of injecting iodoform emulsion into soft thyroid tumors. In every instance there was a diminution in the circumference of the neck amounting to from 8 to 10 cm. Antiseptic precautions were employed and in some cases where the tumor was of considerable dimensions several syringefuls were injected into different parts of the parenchyma. In order to ascertain whether the needle has entered the gland, the patient is asked to swallow, when, if it has so entered, the downward movement of the syringe shows that the needle has been carried upwards. In some cases the injections were repeated daily for several days, in others at intervals of a few days. In no cases were any untoward symptoms produced.—*The Lancet.*

#### MYOPIA IN SCHOOLS.

M. Nimier, according to the *Mercure médical*, has examined this year a hundred and fifty-three young men, candidates for the military schools, of whom he found a hundred and thirty-one to be myopic. From the examination of these myopic pupils he concludes that the defective hygienic conditions often marked as causes of myopia in educational institutions still exist, and among these he emphatically remarks the habitual wrong correction of errors of refraction. The greater number of pupils whom he examined wore glasses chosen by themselves. One extreme case he instances as found among them, that of a young man with hypermetropia who had been constantly wearing a concave lens of six dioptries. Glasses chosen for distant vision serve for near vision by necessity when the students follow demonstrations in class and take notes, hence a spasm of ac-

commodation and a subjective myopia of a degree more important than the real. In the military schools, thanks to the careful correction of ametropias, myopia almost always ceases to be progressive. The most dangerous period is that of severe application and study.—*N. Y. Med. Jour.*

#### ETIOLOGY OF NEPHRITIS.

M. Vignerot (*Arch. gén. de Med.*, October, 1891), says that the tendency even now is to attribute too large a share to cold in the production of nephritis. Taking the infective disease alone, the alterations brought about by the micro-organisms in the renal tissue may pass away without leaving any trace, but they may also become chronic, giving rise to changes in the epithelial elements and to proliferation in the interstitial tissue. Scarlet fever holds the first place, then variola, measles, and also enteric fever and diphtheria may be mentioned. Pneumonia, erysipelas, rheumatism, infectious tonsillitis, and cholera have been cited as giving rise to a permanent albuminuria and likewise septicæmia. The author has reported a case following mumps. Tubercle, syphilis, and malaria have also been added to the list. In some cases the change is not uniformly progressive, but there is an alternation of relapse and improvement, so that a primary renal affection is easily suggested. A case is referred to in which, after scarlet fever, exposure to the least cold produced a considerable increase in a hardly appreciable albuminuria. In some instances the poison would appear to localize itself almost exclusively in the kidney, the cold lessening the resistance of the individual. Direct action of cold upon the kidney cannot be admitted, and it is difficult to conceive how a simple and momentary congestion brought about reflexly could produce a veritable nephritis without pre-existing alteration in the kidney. Cold thus probably gives an impulse to a morbid condition already present, but it cannot create it. Cold is invoked as a cause, because the previous history of the patient is insufficiently known. M. Vignerot refers to a case of severe diphtheria with intense and prolonged albuminuria which subsequently came under treatment for enteric fever with marked renal symptoms.—*Brit. Med. Jour.*

#### IRON IN LARGE QUANTITY IN ANÆMIA.

In a very marked case of anæmia in a young girl of nineteen, H. Taylor, after being assured of the satisfactory condition of the digestive functions, prescribed for her a drink of diluted solution of the perchloride of iron (5-25 drops to 30 cc. (℥j) of water). He gave her to understand that the more she took day and night, the better it would be for her, and the sooner would she recover. She entered heartily into his plans, and in twenty-seven days took almost 900 grams (℥xxx) of tincture of the perchloride of iron (according to the British Pharmacopœia), instead of 100 grams, the maximum dose with most physicians. There were no unpleasant phenomena on the part of the digestive tract. To keep the bowels regular, he gave her daily a pill of aloes and nuxvomica. The result was complete cure after four weeks of treatment. The author recommends this mode of treatment, which allows the ingestion of large quantities of iron, without in any way interfering with the health of the patient. Should the iron commence to show any unfavorable effects (constipation, etc.), the patient should stop the medication, which no longer agrees with him.—*La Courrier Médicale*.—*Cincinnati Med. News*.

#### MEIGS' FOOD FOR INFANTS.

In the *Canada Lancet*, Oct., 1891, Dr. Meigs' method of preparing food for infants who must be weaned is given as follows:—He uses a tall tin vessel with a narrow circumference, holding exactly a quart. In the centre, at one side, an



opening is made which is closed with a rubber cork. He gets as good a milk as possible, buying it preferably from a man who keeps cows, rather than from a middleman or dealer—the chances of adulteration being less. The milk is allowed to stand three hours in this tin. Then the cork is withdrawn, and the upper half of the milk will escape. This half contains all the cream, and Dr. Meigs considers that it is equal to a mixture of cream  $\frac{3}{4}$  ij. and milk  $\frac{3}{4}$  j.; adding  $\frac{3}{4}$  ij. lime water as in his old method, and  $\frac{3}{4}$  ij. sugar water to every  $\frac{3}{4}$  ij. of the above cream mixture. Here we part with him, believing that he uses too much lime water. We prefer to follow from this point the method adopted in the New York Infant Asylum. The cream mixture is obtained as above. It is then diluted equal parts with sugar water of the same strength as above, viz.,  $\frac{3}{4}$  ijss. of milk sugar to  $\frac{3}{4}$  ij. of water. One or two measures of the peptogenic milk powder is added, and it is allowed to stand for three hours—by which time the milk may be slightly bitter—but children take it well. The milk is not thoroughly peptonized by this method and leaves enough work for the stomach to do. Sufficient lime water is now added to turn litmus paper faintly blue. Then the preparation is bottled and sterilized, and is ready for use.

#### CORNS UNDER THE NAILS.

The experiences of Dr. Jonathan Hutchinson are always worth listening to, even when he enters the domain of the corn-doctor. The *Canadian Practitioner* quotes some interesting observations of his on the above subject. He says:—"A corn consists, I suppose, of a mass of much thickened and horny epidermis, under the centre of which, and probably in part as its cause, there is some hypertrophy of papillæ. In warts the hypertrophy of the papillæ is very great, and there is comparatively little excess in the accumulation of epidermis. In the corn the indurated epidermis completely conceals the overgrown papillæ, but it would be, I suspect, a mistake to believe that there is no overgrowth of the latter. Those who have attempted to pare down corns well know that at a certain depth a very sensitive and vascular structure is reached, and in many this is decidedly above the level of the surrounding skin. Corns, according to an observation which was, I believe, originally made by Hunter, usually result from intermittent pressure. If the pressure is continuous, atrophy rather than hypertrophy results; but if it is intermittent there is an opportunity for the structures which have been made vascular by recent pressure and irritation to take on overgrowth. It is somewhat difficult to apply such an explanation to the development of corns under the edges of nails. It is, however, an unquestionable fact that they do sometimes form in this position.

A young lady named S—, aged about 25, was under my care for some time on account of a most troublesome growth under the edge of one of her finger nails which had all the characteristics of an ordinary corn. It was very hard, and had somewhat lifted up the edge of the nail. I pared away both the nail and the corn under it, and then applied strong nitric acid. A sore resulted which took some time to heal; but the end was a complete cure.

The nail of one of her little toes had been quite destroyed by a corn under it."

#### ON THE RESULTS OF TREATMENT OF SIMPLE FRACTURE OF SHAFT OF THE FEMUR.

In a paper with the above title (*Med. News*, Sept. 26, 1891), Dr. Stephen Smith arrived at the following conclusions: A satisfactory result has been obtained in the treatment of fracture of the shaft of the femur when—

1. Firm bony union exists.
2. The long axis of the lower fragment is either directly continuous with that

of the upper fragment or the axes are on nearly parallel lines, thus preventing angular deformity.

3. The anterior surface of the lower fragment maintains nearly its normal relation to the plane of the upper fragment, thus preventing undue deviation of the foot from its normal position.

4. The length of the limb is either exactly equal to that of its fellow, or the degree of shortening falls within the limits found to exist in 90 per cent. of healthy limbs, viz., from one-eighth of an inch to one inch.

5. Lameness, if present, is not due to more than one inch of shortening.

6. The conditions attending the treatment prevent other results than those obtained.

#### THE DIAGNOSIS OF TUMORS OF THE BLADDER.

Dr. Guiard (*Arch. Gén. de Méd.*, September, 1891) says that in these cases it is not always possible to decide the question of surgical interference without having pursued as far as possible the clinical study.

After a historical sketch, in which acknowledgements are made chiefly to M. Guyon for contributions to this clinical diagnosis, the author deals (in this number) mostly with the hæmorrhage occurring in vesical tumors. There are three clinical types of these neoplasms; (1) those in which hæmorrhage is the first and for long the only symptom, urine otherwise altered, frequent micturition, retention, fragments of growth occur more or less late in the disease; (2) those in which symptoms of obstinate cystitis prevail; and (3) those in which the symptoms of hypertrophy of the prostate are simulated. Whatever the onset, hæmorrhage eventually appears, unless in the most exceptional cases. Anatomical observation compared with the evolution of the symptoms enables it to be said that the first hæmaturia is almost contemporaneous with the commencement of the tumor. This hæmorrhage occurs without cause, independently of exercise or effort, and as often by night as day. If sometimes it appears to have been produced by violent movements, its amount and duration are altogether out of proportion to the cause. It may arise after an exploratory catheterisation. Except for the color of the urine the patient would be unaware of the hæmaturia, that is, there is no other symptom. The color varies from a bright to a deep red according to the amount of blood and its length of stay in the bladder. If black it may leave a deposit more or less like coffee grounds. The amount of blood is variable, but it is nearly always considerable, owing to the time the hæmorrhage lasts. Sometimes it is so plentiful as to give rise to clots. These may be elongated, sometimes decolorised, but they most often consist of small soft and black masses. However small, there is much pain in expelling them, and the hæmorrhage is increased. It is not very rare to have complete retention, the clots having accumulated so as to fill the bladder. Here neither urine nor blood is drawn off by the catheter, a fact giving rise to much difficulty of diagnosis. Aspiration with the help of a large-sized catheter must be had recourse to. Very rarely the clot forms a firm spheroidal mass, which behaves like a stone. Each hæmorrhage lasts long—several days and sometimes weeks. It resists treatment both general and local; it stops most often suddenly, sometimes gradually; it soon reappears, however. In exceptional cases the interval has lasted years, but most often it is only months. The intervals become shorter, perhaps (*sic*). Sometimes after repeated and copious hæmorrhages the patient no longer passes any blood, but other symptoms supervene. The health is eventually affected. There is waxy pallor due to loss of blood and œdema of the extremities. In rare cases only small clots are passed, and the

hæmorrhage is then easily overlooked. In cases of hæmaturia, of spontaneous origin, lasting long, resisting treatment, and returning at gradually shortening intervals, one may affirm without hesitation the presence of a neoplasm in the urinary tract. A tumor at the neck of the bladder calls forth earlier troubles of micturition and pain. Fragments of growth in the urine form a valuable but too inconstant a sign. They show the presence of the neoplasm, but say nothing of its nature. The patient should be instructed to look for them.—*Brit. Med. Jour.*

POINTS IN PLASTER OF PARIS WORK.

The following useful hints from the *American Druggist* will be read with interest:—

1. *To Make Plaster Set Hard.*—Mix best plaster of Paris with about 10 per cent. —more or less, according to effect ascertained by preliminary experiment—of very finely powdered marble (calcium carbonate). Or add to it about 6 per cent. of powdered alum, or about the same amount of ammonium chloride, before mixing it with water.

2. *To Make Plaster Set Slower.*—Mix it with 2 to 4 per cent. of powdered althæa root before adding the water. This not only retards the hardening of the plaster, but also enables it to be cut, filed, sawed, and turned.

An addition of 8 per cent. of althæa powder retards the complete setting of the plaster for about one hour, so that the mass can be used for any purpose where it is to remain plastic during at least a portion of that time.

DIPHTHERIA.

Dr. Joseph Burghardt, of Vienna, uses a powder of equal parts of washed sulphur and sulphate of quinine, applied very thoroughly to the pharyngeal walls by means of a powder-blower. In a lecture on this subject, translated by Charles Raettig, the author claims never to have lost a patient from diphtheria since he began to employ this method, having had thirty-three consecutive recoveries of patients from one to twenty-five years of age.—*Med. Rec.*

RINGWORM.

Ringworm of the body is generally very amenable to treatment, judging from the numerous domestic remedies which act so successfully. Sometimes, however, an obstinate case is encountered and recourse is had to the physician. In such cases a rapid cure is desirable, and the application of the following, once daily, for two or three consecutive days, will generally prove successful.

℞.—Hydrarg. bichlorid. . . . . gr. ii.  
Tinct. benzoin co. . . . . ʒ i.—M.

Paint over affected parts. Care should be exercised not to paint too large a surface, as the above mixture is toxic. If an excoriation exists it should not be applied, as it is irritating to the wounded integument.

INCOMPATIBLES OF ANTIPYRINE.

According to Millard and Campbell, the following substances produce precipitates when added to aqueous solutions of antipyrine: Carbolic acid in saturated solution, tannin, mercuric chloride (soluble in an excess of water), infusion catechu, infusion cinchona-bark, infusion rose-leaves, infusion uva ursi, solution of extract cinchona-bark, tincture catechu, tincture cinchona, tincture hamamelis, tincture iodine, tincture kino, tincture rhubarb. The following substances produce coloration when added to aqueous solutions of antipyrine: Hydrocyanic acid, dilute solution, yellow; nitric acid, dilute solution, weak yellow; ammonia-alum, dilute solution, dark yellow; amyl nitrite, acid solution, green; nitrous ether, alcoholic solution, green; copper sulphate, green; ferrous sulphate, yellow-brown; ferric sulphate, blood-red; ferric chloride, blood red; syrup iodidei ron, red-brown.—*Med. Rec.*

## THE BACILLUS OF INFLUENZA.

At a recent meeting of the Société des Sciences Médicales of Lyons, Dr. G. Roux presented a communication (*Lyon Médical*, August 9th, 1891), embodying the results of a research made in conjunction with MM. Pithion and Teissier, on the bacillus influenza. In the blood of patients suffering from that disease a streptococcus was found when the fever was at its highest point; in the urine, on the other hand, diplobacilli were found. The authors conclude that influenza is probably caused by one polymorphous micro-organism which exhibits differences in form in the varying phases of the disease. This may account for the great discrepancies of observation which have been reported. M. Roux showed drawings illustrating the successive transformations of the micro-organism.—*Brit. Med. Jour.*

## A GOUT REMEDY.

A gout remedy, known as "Pistoria Powder," has been selling in Paris for some years past, and the charlatans who monopolize its sale have done quite well with it. It was lately analyzed by M. Chastaing, who found it to contain:

Colchicum (the bulbs),	20. grammes.
Bryonia root,	10. grammes.
Gentian (the root),	10. grammes.
Chamomile flowers,	10. grammes.
Betonica,	50. grammes.

These are well ground together by the vendors, who recommend two or three grammes of the powder to be taken in the morning before eating, stirred in water.

The preparation is made in the Pistorian Convent, and sold in boxes holding 365 powders (one for each day in the year), for about six dollars.—*Bulletin of Pharmacy.*

## TREATMENT OF DYSENTERY BY IRRIGATION OF LOWER BOWELS.

Dr. Koritin reports fifteen cases of dysentery cured by irrigation of the lower bowels. He had nine cases of the diphtheritic form of dysentery and six of the catarrhal (according to Virchow's division of the disease). In two diphtheritic cases a solution of carbolic acid 3j to six pounds of water was used; and in seven, gr. xx to six pounds of water. In the catarrhal form: in two cases, gr. xx; in one, gr. x to six pounds of water; and in three other cases pure water was used. The author, after fully describing each case, concludes his interesting article, saying that though he has used besides the irrigation some of the popular internal and external remedies, nevertheless, he thinks that the course of the disease, as given in his description, was modified by the irrigation.—*Dietetic Gazette.*

## THUYA IN HYDROCELE AND HEMORRHOIDS.

Dr. Howe, of Cincinnati, says that a diluted tincture of thuya occidentalis injected into the tunica vaginalis testis is of great service in hydrocele. If well injected and squeezed into every part of the sac, this will be obliterated, and the effusion will not return. Injections of thuya into hæmorrhoidal tumors promotes their destruction with more certainty and less danger than does carbolic acid.

## ESSENTIAL OIL OF CYPRESS IN WHOOPING-COUGH.

According to Dr. J. M. Bravo (*Revista Medica de Chile*, No. 7, 1891) the most useful drug in whooping-cough is an essential oil obtained by distillation from the needles of the cypress tree. The method of employing the oil is to drop some of it on the clothes near the collar, or at night on the bed pillow, so that the

patients breathe an air constantly impregnated with the volatile principle. The author's experience is summed up in the following: 1. The essence of cypress is the most rapidly successful in the treatment of pertussis. 2. It possesses none of the disadvantages of many of the other known remedies (for example, belladonna, balsams, etc.) 3. It is very easily applied, and has a strong but not disagreeable odor, to which children have no objection and which after a short time they enjoy.—*Brit. Med. Jour.*

A NEW USE FOR ARISTOL.

Dr. James J. Levick, of Philadelphia, writes to the *Med. News*:—"In a case of poisoning of the hands from *rhus toxicodendron*—poison oak—recently under my care, which had reached the vesicular stage and was attended with much swelling and burning, the happiest results promptly followed the free dusting of the powder of aristol on the affected parts. The change was almost magical, so sudden and so prompt was the relief afforded. Might not this powder, applied in the early stage of the disease, do much toward preventing the ulceration and pitting of variola?"

SYPHILITIC ULCERATIONS.

Plumert gives the following applications for ulcers of syphilitic origin:

R.—Mercury salicylate	. . . . .	gr. xv.
Potassium carbonate,	. . . . .	gr. xv.
Distilled water,	. . . . .	℥vj.

M.—Sig., dissolve. Wet compresses with this solution and apply to the ulcerations.

If an ointment is preferred, recurrence may be had to the following:

R.—Mercury salicylate	. . . . .	gr. xvj.
Vaseline,	. . . . .	℥j.

M. and make a pomade.—*Bacteriological World.*

WHOOPIING COUGH AND VACCINATION.

The old belief that vaccination sometimes affords relief from, or entirely checks, the progress of an attack of whooping cough, now receives additional clinical evidence in its support from the paper of Dr. Cachago in the *Wiener Medizinische Blätter* (Oct. 16th, 1890). In five extremely severe cases of whooping cough immediate relief was afforded as soon as the febrile symptoms of vaccinia appeared, and the whole character of the cases were modified and greatly ameliorated.—*Dietetic Gazette.*

VIRCHOW'S OBSERVATIONS ON OLD ATHENIAN SKULLS.

At the last sitting of the Royal Academy of Science here, Professor Virchow made interesting communications regarding his measurements of old Athenian skulls dug out by the late Dr. Schliemann, who was a personal friend of Virchow, from his own ground in University-street in Athens. He found eleven graves there, ten of which, judging by their contents, were of the fourth, and one of the sixth century before Christ. The sarcophagus in this latter grave must have been of wood, Dr. Schliemann thought, for there was not a vestige of it left. All the graves contained human bones, but only four skulls could be taken out in a tolerably unimpaired condition, and these Virchow has measured. All four must have belonged to adults, probably of advanced age. The most remarkable thing about them is the smallness of their capacity. Virchow made a similar observation in 1871 on two skulls dug out in Piræus-street in Athens. One, which belonged to an old woman named Glykera, was of the Macedonian time;

in the other grave, that of a powerful man, numerous clay vessels of the most ancient style were found. On that occasion also, Virchow remarked that the small capacity of those skulls was surprising, being so much below the average of other civilized peoples that one was inclined to suppose them to have belonged to members of a savage race. This singular fact should make one pause before accepting capacity of skull as a measure of the civilization of a race, as some anthropologists have done.

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### Medical Items.

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Prof. John J. Reese has resigned the chair he has so long filled in the University of Pennsylvania. His successor has not yet been appointed.

A well-known practitioner of Ubeda in Spain recently committed suicide because his treatment of a case under his care was disapproved of by two consultants who were called in.

Dr. Thos. B. Evans, Dean of the Baltimore University, died Friday morning, October 30th, at his residence, 121 Jackson Place, after a severe illness. He leaves a wife and one daughter.

Dr. Nardyz, a Pittsburg physician, is at work upon an immense papier-maché model of the human heart, for exhibition at the World's Fair. It will be three feet in diameter.

A union meeting of the Northwestern, the Northern, and the North Central Ohio Medical Societies will be held at Mansfield on Thursday, Friday and Saturday, November 5th, 6th and 7th.

The Duchess Eugenia Litta Bolognini has given 500,000 francs (£20,000), the proceeds of the sale of her jewels, in consequence of the death of her husband and son, to the Ospedale Maggine, Milan, with a special request that the money may be applied for the benefit of the surgical department for children.

Bombelon recommends the meconate of morphine as the most suitable salt for hypodermic use. He states that it keeps well in solution and causes no pain. This has also been the experience in New York hospitals in former years. For some reason not known to us the salt has fallen into disuse.

In the city of Chicago there were more than 200 deaths last month from typhoid fever, which would indicate not less than 2,000 cases in the city at that time, nearly every one of which was produced either by drinking the lake water without sterilizing by boiling, or by the use of milk in a similar manner.

People are sometimes greatly inconvenienced by the accidental swallowing of foreign bodies. It is a common mistake to take purgatives, with an idea of eliminating the article. This is wrong, and may cause death by letting sharp edges or points perforate the intestines. The proper treatment is a diet of potatoes or bread until the article is passed.

Lenevitch emphatically draws attention to a method for arresting obstinate vomiting which so frequently occurs after chloroform anæsthesia, especially in cases of abdominal section. The method consists in thoroughly washing out the patient's stomach with a lukewarm 0.5 or 1 per cent. solution of soda.—*Boston Med. and Surg. Jour.*

The medical practitioners of Hudson county, Nebraska, have combined against the common enemy, the patient who thinks his doctor's bills can stand over indefinitely. A protective association has been formed which sends a collector to interview recalcitrant debtors, and if a settlement is not effected within a reasonable time the defaulters are blacklisted.

It is advisable to call to the physician's notice the fact that calomel and ammonium chloride are incompatible, forming corrosive sublimate. Although the calomel powders are to be taken three times a day, and the cough mixture in teaspoonful doses every two hours, or in other words, never at the same time, the risk is great; an accident may happen and you would be partly to blame for the consequences.

A gentleman writing from Africa to a German contemporary, says that for mosquito bites he has found for his own person nothing better than ordinary soap. He always carries a small piece on his expeditions, and if bitten, makes a lather over the affected part and allows it to dry on; the burning is at once relieved, and all pain ceases. The application can be repeated as often as required.

A degree of the Faculté de Médecine of Marseilles, dated in 1702, establishing a fee bill for the physicians of that place, has recently been unearthed. From it we learn that the charge for each professional visit was fixed at a quarter of a silver crown (about twenty-five cents), no discount being allowed even though several visits might be made in a day. For a consultation the ordinary fee could be demanded of one silver crown, or a dollar.

We are requested to again call attention to the fact that the semi-annual meeting of the Medical and Chirurgical Faculty of Maryland will be held in Rockville, on the 3rd Tuesday and Wednesday in November. The profession throughout the State is cordially invited to take part in this meeting. Any one desiring to read a paper at this meeting is requested to forward the title of the same at once to Dr. T. A. Ashby, chairman of the Executive Committee. It is proposed to issue a programme at an early day.

Dr. Cold, a German specialist, comes out strongly for more sleep for children. Infants, he says, should sleep most of the time, and this is generally allowed them. But children from six to seven are robbed generally of their sleep, and the change affects their health. From 10 to 11 the average child only gets 8 or 9 hours' sleep, while he needs 10 or 11. Until one is 21, 9 hours' sleep is necessary to keep up the physical balance. Even an adult, the German specialist thinks, needs from 8 to 9 hours' sleep every day.

In regard to foreign professional visitors to Chicago, probably the number will be greater than most anticipate. More than one gentleman in Berlin told me that he was coming. It must be remembered that I met very few physicians there, except those especially devoted to obstetrics and diseases of women. Dr. Auvard is coming, and, like others, he is desirous of making his visit at the time when some of our national medical societies shall be in session, in order that he may meet as many of the profession, or at least as many of those that are engaged in his special department, as possible. Ought not the profession of the United States to take measures to secure the realization of such desire?—*Cor. Med. News.*

Dr. Carl Maydl, extraordinary professor of surgery in the University of Vienna, has been appointed ordinary professor of the same subject in the Czech Medical

Faculty of the University of Prague. Professor Du Bois-Reymond has been elected Dean of the Medical Faculty in Berlin. Professor Gartner, of Jena, has been appointed to the chair of hygiene at Marburg, made vacant by Professor Rubner's appointment to succeed Koch in Berlin. Mosevig-Moorhof has been given charge of the second surgical department of the Vienna General Hospital, formerly under the charge of Salzer, deceased.—*Boston Medical and Surgical Journal*.

At the conclusion of the Seventh Congress of Hygiene and Demography it was announced that Dr. Körösi had offered a prize of 1500 francs (\$300) for the best work on the subject of demography and its progress in the chief countries of Europe and the United States. Essays, which must be written in English, German, French, or Italian, must be sent by January 1, 1894, to the Permanent Committee of the Congress. The name of the author is to be sent with the essay, but in a sealed envelope. The paper will be examined by an international committee of five statisticians elected by the Permanent Committee, but not necessarily members of it. The prize will be awarded at the opening meeting of the next Congress of Hygiene and Demography at Budapesth.—*Medical News*.

It seems almost incredible that a half-century ago, on the occasion of the opening of the first railway in Germany, the Bavarian Medical Faculty denounced the innovation as follows: Conveyance by means of carriages propelled by steam ought to be prohibited in the interest of public health. For the rapid motion cannot fail to create a disease of the brain among passengers, which may be classed as a species of *delirium furiosum*. Even if travellers are prepared to run the risk, the onlookers ought by all means to be protected. The mere sight of a passing train suffices to cause the same cerebral disorder. Wherefore the authorities should insist on having a palisading of thick boards, at least five feet high, placed on each side of the permanent way.

Peter Moeller, of Christiania, the well known manufacturer of cod-liver oil, has obtained patents for an improved process of obtaining cod-liver oil free from the more or less rancid or fishy taste which accompanies the oil so commonly. The process is an old principle applied to this particular product. It consists in preventing the access of air during the trying-out of the oil, as it has been found that any rancidity is due to the oxidizing action of the air upon the fatty acids of the oil. The trying-out is carried on in specially constructed boilers, through which a current of an indifferent gas (carbonic acid) is constantly passing. This displaces not only the air in the apparatus, but also that which is gradually given up by the livers themselves. When the trying-out is completed, the current of gas is maintained until the contents of the boiler are cold.

The State Board of Regents of the University of Texas, on the 27th ult., completed the election of the Faculty for the medical department of the State University. Dr. J. M. T. Flemming, of Baltimore, was elected Professor of Surgery, at a salary of \$3000 per annum; Dr. Edward Randall, Galveston, Professor of Materia Medica and Therapeutics, at a salary of \$2,500; Dr. Allen J. Smith, Philadelphia, Professor of Pathology, Bacteriology, and Histology, at a salary of \$2,000 per annum; Dr. A. G. Clopton, Jefferson, Professor of Physiology and Hygiene, at a salary of \$3,000 per annum; Dr. William Keeler, Edinburgh, Scotland, Professor of Anatomy, at a salary of \$2,500 per annum; Dr. Seth M. Morris, Austin, Professor of Chemistry, for one year, at a salary \$2,000 per annum; and Dr. George H. Lee, Demonstrator of Anatomy.—*Medical Rec*,



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## CONTENTS

### ORIGINAL ARTICLES.

Obstruction of the Bowel. By M. Price, M. D.,  
of Philadelphia. . . . . 23

Professor Rudolf Virchow. By Samuel C. Chew,  
M. D., Baltimore. . . . . 29

### EDITORIAL.

A Substitute for the Telephone. . . . . 32

A Dangerous Method of Stating Dosage of Drugs. 33

The Expectation of Reward in Medical Practice. 33

On Brevity in Medical Literary Composition. . . 34

REVIEWS, BOOKS AND PAMPHLETS. . . . . 34

### MEDICAL PROGRESS.

Salicylamide.—Modified Operation for Squint.—  
Active Principle of Wood Anemone.—Hypodermic  
Injections of Sodium Chlorid in Angina.  
—Petroleum Rectum.—What Modern Therapies  
applies May Lead to.—Surgical Obstetrics in  
Gynecology.—Influence of Chloral on Circula-  
tion.—Morphia in Pregnancy, Parturient and  
Nursing Women.—Wiesner's Chloroform Preser-  
vative Fluid.—Cowler's Colic for the Cure  
of Warts.—A New Use for the Ovar.—Dis-  
crimination Between Myalgia Eruptiva and Lumbal  
Spasm.—Incompatibility of Oxide of Potas-  
sium and Chlorate of Potassium.—The Treat-  
ment of Bronchism.—A Medical Centenarian.  
—Beware of the Free Use of Cocaine in Hay  
Fever.—The Cure of Chronic Peritonitis by  
Laparotomy.—Dr. Koch's Tuberculin.—Neu-  
ralgia.—Treatment of Stye.—Treatment of Mi-  
graine.—Treatment of Old Ulcers of the Leg. 36

MEDICAL ITEMS. . . . . 43

## Original Articles.

### OBSTRUCTION OF THE BOWEL.†

BY M. PRICE, M. D., OF PHILADELPHIA.

The treatment of obstruction of the bowel is a subject of the greatest importance to the public as well as the profession. There is no subject or condition where life so positively depends upon a proper appreciation of the condition and immediate and correctly applied surgical treatment.

There is no condition where the complications are so varied, from simple hernia to virulent malignancy; there are so many conditions that will produce obstruction, that the wonder is that any of us get through life with a complete and healthy bowel in our body.

The causes of obstruction are almost innumerable, and every case is one to be dealt with in a manner peculiar to itself. The life of the patient depends upon the ability of the operator to cope with the complications, more than any other factor.

To appreciate the difficulties to be overcome in this department of abdominal surgery, one has but to examine the work of Senn and a host of others who have done work in the abdomen, and ask any one of them what part, if any, is easy of accomplishment.

In most cases of obstruction of the bowel there is no indication or symptom to indicate or direct us to the point of obstruction.

†Read before the Philadelphia County Medical Society, October 11th, 1891.

We have a patient with an enormously distended abdomen, with symptoms of peritonitis, with fecal vomiting, with pulse and temperature to indicate a condition of things for most urgent and prompt action. Or we may have an obstruction with scarce one of these symptoms to direct us in our investigation. Help can only come to a patient suffering thus from one who can correctly read the symptoms and correctly interpret their magnitude. Abdominal surgery for many years offered hope of relief to a very small number of abdominal diseases, but now surgery has thrown open the door to all who suffer with abdominal disease with the same opportunity for relief that the surgeons offered only a short time ago for ovarian tumors, with a vastly improved method and a greatly reduced death-rate.

In obstruction of the bowel there are so many questions and conditions to be considered before operation, that when the time comes to operate, it is very much like a well-planned battlefield with every division in position and all the minor details settled: the work of battle begins and the surgeon only waits the development of the enemy or disease with which he has to contend in the completion of his work in the removal of the conditions present.

The first question to be decided is: Is there a strangulation present, or an obstruction, or a condition of partial paralysis induced by over-distention by a costive habit, or a condition produced from loss of proper nerve force for the performance of bowel digestion and elimination, or is it a paralysis following convulsion with general paralysis of the entire body? All of these questions have to be answered some time in the experience of every operator, not all in the same case, but they all have a place in the consideration of the question in hand, and the operator who does not keep his mind impressed with such possibilities, will sooner or later have cause to regret.

There is no better place than just here to relate a case in point. Dr. Ewing, of West Grove, asked me to see a patient with symptoms of obstruction of bowel, in a woman sixty-five years old, who had been suffering for five days from great distention, the bowel showing through the abdominal wall very much like a mass of sausage under a linen cloth, an increased pulse and a temperature something above the normal, but not enough to indicate a serious condition. The other symptoms indicated an element in her condition that led me to investigate further for a cause. The doctor had used all the agents, purgative and otherwise without effect; the stomach now refused all drugs. The daughter stated that the patient had a convulsion two nights in succession before the doctor had been called to the case, and that she had been quite stupid and unlike her usual self since that time. The knuckles of intestine lay without a particle of movement, no peristalsis; in fact, there is a condition of paralysis following a convulsion that so closely simulates obstruction, that it is with great difficulty that we come to a proper appreciation of the symptoms. This patient had also vomited very questionable matter, and together with the other symptoms seemed a plain case for operative treatment; but there was a question of doubt, and after waiting a period, with sulphate of magnesia in large and repeated doses by injection, brought the result, clearly showing that we must be on our guard with every case.

The stomach exercises a marked influence in obstruction of the bowel; the changed current and direction of the bowel contents in its effort to find an exit, changes the stomach from an organ for the digestion of food to that of a pump for the elimination of the contents of the bowel through the mouth, and by so doing gives us a direct and positive indication for treatment, which to be most effective must precede any operative treatment that may be required.

We should empty the stomach and wash out all the contained fluid and solid contents. How best to do this is a question by no means yet answered. For my part I much prefer the stomach, aided by warm water and a mild emetic, to do the work, when the patients are in a condition to warrant such an effort, but many of them are not; then only the pump must be used. It is a most disagreeable instrument and should be used with great care, and not removed until all the work of flushing the stomach is finished. If you operate for strangulated hernia after there has been fecal vomiting and leave the stomach to get rid of its disagreeable contents as best it can, you have but half done your work, and more than probably the portion left undone will finish your patient.

In a complete cleaning out of the stomach you have added greatly to your patient's comfort and to his immediate and rapid recovery, beside having left nothing in the way of a clear surgical conscience. Therefore a stomach-pump is requisite to perfect work in obstruction.

*Treatment.*—The saline treatment of complicated inflammatory conditions and those simulating inflammatory obstruction of the bowel is oftentimes of value, first in clearing out a bowel not obstructed, but torpid and distended with all the filth of months; again, in actual obstruction, where we have a condition of paralysis produced by the inflammatory condition, which can best be removed by sulphate of magnesia. The effect of the saline does not in the least hinder the operative treatment, but prepares the patient for a much more speedy recovery from the effects of the inflammatory condition and the operation for the removal of the cause of the obstruction. If the obstruction be purely mechanical, then the saline aids the efforts of nature to promptly throw off all the retained and decomposing materials remaining dammed up in the intestine by the obstruction.

After an obstruction of the bowel has existed, even for only a short time, the distention has in most cases been so great that it takes a long time for the bowel to recover its tone and normal function, and if the saline treatment has been used before the operation the time for recovery will be much shortened and the risk and suffering of the patient correspondingly lessened. All those who have done intestinal work have been impressed with the length of time after an operation for strangulated hernia before any action of the bowels can be had, even with salines. I have had as much as six and eight days pass before I could get the bowels moving in cases of obstruction of the bowel from inflammatory incarceration. And in another case as many as eleven days intervened after a resection of five inches of obstructed colon from epithelioma and uniting them by the Senn method. In this case four ounces of magnesia sulphate were given before any result. In several of my cases I feared that I would have to do them over; and I have no doubt the abdomen has been reopened many times after abdominal operations for a supposed obstruction when none existed. So great care and judgment is required in these cases, that something positive only should drive us to a second operation. Simple want of a movement of the bowels should put us on our guard and watchful for more certain symptoms of obstruction.

Now as to how sulphate of magnesia will give the best and quickest result: Small and repeated doses diluted with as much water as the patient will take is by all odds the best mode of giving the drug. When the stomach is irritable and sick, it is best given by injection per rectum—an ounce of the drug in half a pint of warm water. If you can give by the stomach and bowel at the same time, you will soon get the result.

There can be no objection to other drugs being used, such as the mild chloride

of mercury, Rochelle salts, that will accomplish the object for which we use purgative treatment. Mixed treatment of opium and purgatives does no good, but introduces an element of doubt and danger that is hard to estimate; it also tends to prevent a proper appreciation of what nature is doing to save the internal viscera from permanent destruction and death. If we give purgatives we must give them for a purpose, and until that object is attained, we should wait until we are perfectly satisfied that nothing but an operation will open the way for a passage, or that our patient cannot be relieved, and then the opium treatment will be appropriate; then use it, but not while there is a chance for the patient's recovery.

*Mode of Operating.*—The method of operating for strangulation of the bowel or hernia is of great importance and should be seriously considered before operation. The method of cutting directly down on the hernia will not answer in all cases: old irreducible hernias, where both sides are down and irreducible with symptoms of obstruction; double femoral, also irreducible, and cases where there are no external symptoms pointing to the location of the disease—these can best be dealt with through a median incision.

The usual opening for abdominal operations of one and a half inches is plenty of room in which to do all the work that is required for the relief of the patient in most cases, and when we find we require more room, it is easy to enlarge the incision. Through this opening a thorough investigation of the abdominal cavity can be made, the old hernial irreducible protrusions can be examined with two fingers in the peritoneal cavity, and the seat of the strangulation located.

The fact that there is a hernial protrusion on either side is no proof that one of them is the point of strangulation; it may be anywhere in the length of the intestine. Then, to open such a patient over the supposed point of strangulation would greatly complicate the case and leave the surgeon in doubt as to whether his patient had been relieved of his strangulation, for often in operating for strangulated hernia, I have had the intestines slip from the sac into the peritoneal cavity, and it was considerable trouble to get hold of the portion strangulated so as to examine its condition before closing up the abdominal cavity. Until the point of strangulation is found and examined, you can never be sure your patient is relieved of his dangerous condition.

Then, again, there is no better way to ascertain which is the obstructed side save through a median incision, both sides being within easy reach, and can be examined and dealt with with certainty. When the position of the strangulation is determined, it is an easy matter to cut down and release the hernia from its sac and return it to the inside, and bring the intestine to the median opening, and there examine its condition, and if there is a show of returning life to the strangulated portion, then wash with warm water that has been boiled, and return to the peritoneal cavity with as little delay as possible. The closure of the wound is of moment, for on the manner of doing this depends the success of a radical cure of your patient.

Leaving the sac outside in position, and taking a long, straight needle, and with two fingers in the peritoneum, push the needle through the abdominal wall, taking care to include all of its wall, so that when it is closed there will be plenty of tissue; it does not require to be very tightly tied, but just sufficient to make a perfect approximation. Before making your closure, trim up your sac and remove all portions thickened and diseased that could interfere with perfect union of the hernial wound.

The inside fingers act as a guide to protect the bowels and to aid to a proper placing of the sutures, and as the sutures are being tied assure yourself that all

is clear and a perfect closure made. This can be determined with perfect accuracy.

The gaseous distension of the abdomen is a most serious complication, and offers many impediments to a proper diagnosis; that it must be gotten rid of before the patient be relieved is admitted by all. Puncture through the abdominal wall with any instrument is dangerous in the extreme; to use a hypodermic needle would be a useless procedure, as much larger openings are required before the gas will be discharged. I have repeatedly tried to empty the bowel in this manner, and feel confident that it would require days to do so. An opening should be made with the knife or some instrument that will puncture the bowel, and the instrument then opened, stretching the bowel, and giving exit to the gas. For this purpose I have had an instrument made almost identical in form with the little ear speculum, bringing the trumpet to a point, with which to make the puncture. The opening can then be stretched, and the closure will require only one stitch, while that made by a knife would necessitate several. I have used it only once. It answered the purpose admirably. As the needle rapidly enlarges from its point the bowel must be grasped by the fingers to prevent slipping while being dilated. Besides this advantage the instrument shortens the operation, lessens the shock, and prevents leakage. Comparing methods of treating obstruction of the bowel, there is but one treatment, that is, to open the patient and correct the trouble—when I say that I do not mean that there shall be a half dozen consultations before this treatment is resorted to, and I will venture to say the mortality will be reduced from its present high figures to 15 per cent. Those credited cured by other methods in most instances were mistakes in diagnosis. No one was ever killed or their danger increased by an exploratory operation.

Much of the recent work done in abdominal surgery has been by men who base their opinions on experiments on dogs. This work accomplishes only one good—it prepares the surgeon with manipulative skill and dexterity in operating. But this experimental or dog surgery has not a single feature in common with that on the human subject, for there is no resemblance either in the operation or the conditions present. The one is on a healthy animal with an intestine only one-third the length of the human, which has been used for the passage of the coarsest food and the most indigestible materials.

With no nervous element to contend with, no pathological conditions to contend with, no distention or delay, no previous shock or destruction of parts, no inflammatory element to remove, no complications to hinder or delay the operative work, no half-dozen consultations, no opium or belladonna previous to operative work—in fact, the one differs from the other as day differs from night. And it is these very conditions, and complications, and delays that make all the difference between life and death. Could we bring the profession to look at the conditions and dangers of peritonitis and obstruction of the bowel in its proper light, and have all such conditions treated at an early period, there would be some chance for the patient to recover from the mischief already done by the disease, for intra-peritoneal inflammatory conditions soon destroy life. The surgeon cannot do any harm nor add one feather's weight to the already dangerous condition, but with good work will save hundreds of valuable lives. Senn's experimental work on dogs was for a definite purpose, which he has beautifully set forth in his book, and clearly demonstrated to us all, and those of us who work in this field can only hope to be imitators of him.

Dr. Theodore McGraw, of Detroit, gives us a most ingenious method of managing some of the more desperate cases of intestinal obstruction. In complete

gangrene of the bowel I imagine it will be of great service in saving life. In these cases we are compelled to make an artificial anus, which will relieve the urgent symptoms of distension, while, at the same time, the rubber ligature recommended by Dr. McGraw passed through two or three inches below the artificial anus, through the upper and lower segments of intestine, including at least one and a half inches, and tied as tightly as possible, and the knot secured by ligature; then either a continuous or interrupted Lembert suture around this ligatured portion, and, by the time the ligature has cut its way through, the union will be complete, without any possibility of leakage, and with but little delay or prolongation of the operation.

Complete exit will be given through the artificial anus to all distending gases and contents of the bowel, until the artificial opening is complete (which is three or four days), when the artificial anus can be closed by silkworm-gut sutures placed at the time of operation. This method also comes to our relief in obstruction of the gall-duct. In these cases the abdomen is opened, the gall-bladder emptied of its contents, the rubber ligature used to unite the intestine to the gall-bladder, the additional suturing of the peritoneal covering of the bowel and gall-bladder, so as to insure perfect union, and in three or four days the abdominal wound can be closed with silkworm-gut sutures; the fistulous opening between the gall-bladder and bowel—made by the rubber ligature—will prevent many of the annoyances and inconveniences of having a biliary fistula.

It will in many ways answer a better purpose than the Senn method, but in the vast majority of cases Dr. Senn's method of anastomosis is our only one to save life; we cannot wait two or three days for an opening to be made; therefore, of necessity, we must resort to the method of Senn.

I have used Dr. Senn's method three times, with two recoveries, and must say I have more admiration for him and his work than any intestinal surgeon in the world.

I have found, in using the Senn plate or the Abbe catgut ring for intestinal anastomosis, that one of the greatest difficulties to overcome was the passing of the silk ligatures through the intestine, there being four or six of them in each plate or ring. When they were threaded in the ordinary sewing needle they became entangled and greatly prolonged the operation, or, if they had to be threaded during the operation, it was the cause of considerable delay, and for a long time I have been trying to find a substitute that would answer the purpose without any of the objectionable delays. I have found the desired needle in the self-threading Supplee sewing-machine needle. In the use of this needle the operation is shortened at least four-fifths, all of the threads being passed rapidly and without delay.

The ring or plate placed in position, the operator holds the needle with the open face of the eye toward him, the assistant takes up the ligature, draws it taut at right angles to the needle over the eye, and it is at once threaded. The operator quickly passes it through the intestine, half an inch from its cut border, and the assistant withdraws the ligature from the eye. The same process is gone through with all the sutures, and it is done in a moment, without delay.

"Ashhurst tabulated 57 cases of laparotomy for acute intestinal obstruction from other causes than intussusception, from which it will be seen that only 18 terminated favorably. At that time the mortality of laparotomy in cases of intestinal obstruction other than intussusception was over 68 per cent. Most of these operations were performed without antiseptic precautions."—Senn, page 28.

I have had a greater number recover from this operation, and have operated

for obstruction only 24 times, and always without antiseptic dangers; only clean Philadelphia water; 19 recovered.

Dr. Ward, of Topeka, Kansas, recommends a most ingenious method for finding the proximal and distal ends of the intestine. Pass the fingers directly down to the attachment of the mesentery to the spine; and the position of the two ends will be immediately established, as the lower attachment of the mesentery must of necessity belong to the lower end of the bowel.

### PROFESSOR RUDOLF VIRCHOW.†

BY SAMUEL C. CHEW, M. D.,

Professor of the Principles and Practice of Medicine in the University of Maryland, Baltimore.

Mr. President, Ladies and Gentlemen: I am perhaps too bold in venturing to speak of the achievements of the great medical scholar and worker, whose birthday we celebrate to-night, in the presence of those who have known him personally and sat under his teachings, while it was never my own privilege to hear his voice or to witness his skill. In my younger days, when I was seeking the advantages of professional study in Europe, the medical resources and attractions of Paris were held by my advisers, perhaps erroneously, to be greater than those of Berlin or Vienna. It may be that they were unduly and disproportionately thus regarded. But it so happened that while I listened to some of the latest teachings of Professor Virchow's brilliant contemporary Trousseau,—*Virgilium tantum vidi* (and who that ever heard him can forget that charm of utterance and those stores of learning which combined to make him one of the greatest clinical teachers that ever lived?), yet I have formed acquaintance with the work of the great German master only through his writings. These have indeed made him known wherever in the civilized world medical science is cultivated, and have given him "a name forever." And yet so far apart from many of the usual paths of life does much of the field of medical labor lie, that it is questionable whether very many persons outside of the profession of medicine are aware of the great and multifarious work that he has accomplished. This cannot be considered strange, however, when we reflect upon the indifference, or worse than indifference, with which other earnest workers in medicine have been regarded. Take an instance: The lives saved by the result of Jenner's scientific work are to be counted by thousands of thousands; yes, when the future as well as the past is kept in view, by millions upon millions. And yet a few years ago his countrymen by express decree removed the statue erected to him in London to make room for that of a military hero. Was not this in every sense a monumental instance of ingratitude? "In the corrupted current of this world" such things can be, but in the hereafter at the coming of a better time, when the victor in battles where multitudes have met wounds and agony and death is no longer thought of, the name of Edward Jenner will still shine on brightly and beneficently, "as the stars, forever and ever."

The field of medicine in its chief divisions of pathological research, clinical observation and therapeutic appliance is so extensive that it seldom happens that any one worker, however great his ability and his energy, can obtain the highest excellence in all of these departments. The most strenuous and successful students of pathology are often not the most noted diagnosticians or therapists; and the converse of this is of course equally true. There are, no doubt, some men of genius, the depth of whose knowledge is equaled by their versatility, who

†Address delivered October 13th, 1891, at a meeting held in the Johns Hopkins University, to celebrate the seventieth birthday of Professor Virchow.

seem to have mastered all these branches of medical science. But even with them there is apt to be some inequality of attainment in the different departments, so that their learning in one, though great, may seem lessened by comparison with their supreme accomplishment in another. This state of things may be found in all departments of knowledge or of mental work. In a course of lectures on the Greek Lyric Poets, delivered a few years ago in this University by that eminent scholar Professor Gildersleeve, he expressed the opinion, (though I cannot now recall the graceful words in which it was uttered), that the merits of Solon as a poet have failed somewhat of being duly appreciated and of obtaining the recognition to which they are entitled, in consequence of his transcendent reputation as a statesman and legislator; while he was in truth (so far as can be judged from the few fragments of his writings that have come down to us), a notable poet, besides being a great law-giver.

In like manner it may, perhaps, be said of Professor Virchow, that his great achievements as an original investigator in the domain of pathology have caused his work on the clinical side of medicine (a work, in some of its aspects, as different almost from that of the pathologist as is the making of poetry from the making of laws), to be somewhat less regarded than it otherwise would have been, or at least to have had less to do with the establishment of his great reputation. And the distinction thus drawn between his comparative powers and attainments in these different departments of professional work should not occasion surprise. For, though possessed, as was said of Lord Truro, of "talents enough to succeed without industry, and of industry enough to succeed without talents," he could not be expected, with all his talents and with all his industry, to accomplish an almost superhuman task.

A parallel case, though with a reversal of the conditions, is seen in the history of that brilliant luminary of medical science, Laennec, who will be known through all time as the discoverer—in as real a sense as was Columbus the discoverer of America—of that great instrument of clinical work, the science of auscultation; a science which, as it issued in almost complete development from his thought, may be justly regarded as one of the most marvelous monuments of the acuteness and power of the human mind. It was as a clinician and for what he supplied to clinical investigation that Laennec won for himself an everlasting fame. And yet it was in reference to his work in pathology that Rokitsansky, himself a master in that work, declared that "had Laennec done nothing else for medical science, his discovery of vesicular emphysema" (an important and most interesting affection of the lungs), "and the causes giving rise to it, would have sufficed to render his name immortal."

Laennec was not supreme in the field of pathology only because he was supreme in that of clinical investigation; and so, if Professor Virchow is in any degree short of the very highest place in the domain of clinical medicine, it is because he has made for himself one higher still in that of pathology. And yet, even if he had not been the author and founder of the Cellular Pathology, which has made so deep an impression on medical thought, that its traces will be felt so long as disease is studied and those physical troubles last to which "man is born as the sparks fly upward," even then his clinical researches into the subject of leukæmia (made known to the medical world when he was but twenty-four years old), into the subjects of chlorosis, of diphtheria, of pigment induration of the lungs (I trust I may be pardoned by the non-medical portion of my hearers for this technical enumeration), and into many other conditions involving the closest clinical study, would have commanded the admiration of all future generations of medical men.



Quite lately there has been seen an instance of his care and caution as a clinical observer, possessed as he is at a ripe age of that "old experience" which

"doth attain

To something like prophetic strain,"

and which, had it been consulted earlier, might have prevented a vast amount of bitter disappointment. I refer to the warning voice which he raised against over-sanguine expectations in the use of the tuberculin.

And perhaps it may not be amiss in further illustration of his caution and conservatism to mention another utterance of his upon a subject beyond the pale of medical science. "You are aware," he said some years ago at the annual meeting at Munich, of German Natural Philosophers and Physicians, "you are aware that I am now specially pursuing the study of anthropology; and I am bound to declare that every advance which we have made in the province of pre-historic anthropology has removed us further from the proof of a connection of man with the animal world. We cannot teach, we cannot pronounce it to be a conquest of science, that man has descended from any other animal." In this famous question he appears, like Lord Beaconsfield, to have placed himself "on the side of the angels." There are some who find a satisfaction in tracing their descent from the primeval jelly; others there are who still think that in their origin and their nature there is something which they share with the angels. "The interpretation of the highest nature is the highest science;" said the great Tory Earl in his famous speech in the Theatre at Oxford: "Man is the highest nature; and when it is the question, 'Is man an ape or an angel?' I, my lord, am on the side of the angels."

The name of Virchow will always be especially associated with the purely scientific part of medicine. In the construction of his great system of pathology he has shown, what has been often witnessed in the higher fields of science, the power and office of the imagination in going before and lighting the way to the greatest discoveries. Those higher regions border closely upon

"The realms of gold

Which bards in fealty to Apollo hold;"

and it was a true instinct of the Greek mind which placed poetry and science under the tutelage of the same divinity.

It was through his imaginative power that Goethe made discoveries of the highest value in anatomy and botany, and foresaw that working of the law of evolution throughout the natural world, which has since his day been more fully revealed. It was through his supreme imagination that Shakespeare could tell how the heart is "visited by its ruddy drops," though Harvey's work was not done until long after those words were written; and by a wondrous anticipation of what was to be revealed at a far later day, even in our own time, could speak in express terms of what we now call septicæmia, when he told how "the life of all the blood is touched corruptibly."

"Had he been one of us," said the spirit in Manfred, "he would have made an awful spirit." And so the votaries of science might say of some great imaginative poet, "had he been one of us, he would have been a mighty power in science." Then there might have been seen another Kepler, another Newton, another Darwin, or another Virchow.

The great pathologist has completed the seventieth year of a life devoted to the good of mankind. "His sun has veered a point towards the west;" but let us hope that many more years of noble work, to be a further boon to humanity and a further honor to the medical calling, are still before him; and that at that distant day when his honored life shall close, he may find his place "on the side of the angels."

**THE MARYLAND MEDICAL JOURNAL.**

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BALTIMORE, NOVEMBER 7, 1891.

**Editorial.**

## A SUBSTITUTE FOR THE TELEPHONE.

The war between the telephone company and the telephone subscribers of Baltimore is not yet over. Most of the druggists had their telephones removed some time ago, on account of the high charges of the company and its effort to secure an additional payment from every non-subscriber who used a subscriber's telephone. As all of the messages from patients to their family physicians had come through drug stores, the doctors likewise gave up their telephones; so that at present the telephone is to physicians as if it had never been invented. Just at this time there appears upon the field a company which offers for fifty dollars a year (one-half the rent of a telephone), to place in the doctors' offices and the drug stores an instrument which will receive messages sent over an electric wire, and will *write them down* on a slip of paper; doing away with the shouting and the errors of the telephonic method; requiring no one to receive the message; and preserving the message till the doctor comes in from his rounds, if he does not happen to be at home when it arrives. The writer has recently had the pleasure of examining such an instrument and watching the little pen as it wrote down messages from an operator several squares away. The only difficulty about the writing is on the part of the sender, who finds it awkward at first to write his message on a flat plate less than an inch in diameter, with a pencil point which cannot be lifted from the plate. The reproduction of the writing on the ribbon of paper, moved by clockwork at the other end of the circuit, seemed to be easy and accurate. The instrument appeared to be simple in construction, and not likely to get out of order. If the instruments furnished physicians are as good as that seen by us, they will soon take the place of telephones for office use.

## A DANGEROUS METHOD OF STATING DOSAGE OF DRUGS.

In giving the dosage of sparteine, an exchange states that it is "3-10 grains." On reading this statement, one would naturally suppose that the proper dose of this new preparation is from 3 grains to 10 grains. On the contrary, after consultation of certain new text-books, he finds that the ordinary dose should be  $\frac{1}{10}$  grain, which may be increased to 2 grains, if necessary. It is evidently intended, therefore, by our exchange, that "3-10 grains" should be interpreted as meaning " $\frac{3}{10}$  grain." The danger of such methods of writing dosage is evident. In a certain prominent German journal the reader is frequently confused by this custom of employing the horizontal dash between the figures in the statement of dosage. It would be much safer to avoid the horizontal dash in this connection, and to write either "the dose is *from 3 to 10 grains*," or "the dose is  $\frac{3}{10}$  grain." In stating the doses of drugs, a writer is criminally careless if he writes in such a way as to mislead an unguarded reader.

## THE EXPECTATION OF REWARD IN MEDICAL PRACTICE.

It is probable that a very large proportion of the young men who enter upon the study of medicine are influenced in their choice by the belief that the practice of this profession presents a wide field of usefulness and benevolent service to their fellow men. After they have entered upon the life of the practitioner the question of pecuniary reward for their labors forces itself more and more sternly upon their attention.

In former times there was a certain security about a well-earned family practice. Patients were bound by the strongest ties of allegiance to the man who had guided them, perhaps since infancy, through the perils of disease. Since the advent of specialism, it is said, these ties have become less binding; many patients going to one physician in one illness and to another in the next, according to their estimate of the special skill, in each case, of the doctor chosen. This has of course rendered the pecuniary outlook for the ordinary physician less certain.

A clientage gained by long years of faithful and skillful attendance may forsake him in a few months, in favor of some newly arrived doctor, who may be his inferior in experience and skill, but may take more energetic measures for capturing the public fancy.

The question before us is, whether or not this uncertainty in the reward of faithful medical labor is to the advantage of the community. We believe that it is altogether injurious. The most striking illustration of the evil influence of this uncertainty of reward is found in the government service of this country, where thousands of employees are liable to be suddenly deprived, for insufficient reasons, of their means of support after every important election. The corrupt dealings and imperfect service which this uncertainty produces are well known to every observer.

We are not condemning fair competition in medical practice. But it is certain

that sudden and unreasonable shiftings of clientage from one practitioner to another, changes which are not permanent but rest on passing whim or misleading advertisements (whether in the public press or through emotional patients), are no more beneficial to the community than to the family practitioner. This is really the ground on which the much-berated code of ethics rests its precepts.

This code is right in teaching that the physician should patiently win his clientage by quiet, faithful work, not endeavoring to entice patients away from his fellow practitioners; and that patients should not desert well-tried family physicians without careful consideration and good cause.

#### ON BREVITY IN MEDICAL LITERARY COMPOSITION.

In this age of enormous literary activity in the field of medicine, no intelligent writer, unless he is a person of high position or great personal reputation, offers to the public or to the press long prosy dissertations or compilations; because every literary worker possessed of tact and experience knows that no one but the "book-worm" will read such productions. The editors of the best journals, therefore, reject such articles, or with the consent of the authors cut them down to a proper size. The ordinary writer who wishes his communications to be read must cultivate a style which meets the needs of the age. He must aim at a terse, clear and exact expression in words of the thoughts which he wishes to impress upon the mind of the reader. He should remember that the journal of thirty or forty pages needs much shorter articles than the journal of more than one hundred pages; perhaps less than half as long. Its readers demand several original articles in each issue. They are dissatisfied if one writer occupies the whole space, and will not even read his article. The best article for the average reader is one in which the author strives to present important facts or experiences in a condensed form, pruning off any unnecessary wordiness, and all personal explanations and ultra-scientific disquisitions, which, though interesting to the writer, beget a sense of extreme fatigue in the reader. Some medical writers affect a style which would have been much more highly appreciated in the antediluvian age, when a man could have easily devoted six months or a year to the perusal of a journal article. In these degenerate days the speaker or writer, who desires an audience, must learn to say what he has to say and then stop.

Short, pithy communications are always a comfort to the editor and a delight to the reading public.

#### Reviews, Books and Pamphlets.

*Lectures on Tumors from a Clinical Standpoint.* By JOHN B. HAMILTON, M. D., LL. D., Professor of Principles and Clinical Surgery, Rush Medical College, Chicago, etc. George S. Davis; Detroit, Mich. 1891.

The lectures here collected are stenographic reports of those delivered by Prof. Hamilton in his hospital work. The author is a remarkably clear lecturer and

his discussion of symptoms and treatment is full and suggestive. It is a little work which cannot fail to be read with great benefit by both student and practitioner, the price, 25 cents, being so small as to place it in easy reach of all.

*Artificial Anæsthesia and Anæsthetics.* By DEFOREST WILLARD, R. M. M. D., Ph. D., and LEWIS ADLER, JR., M. D. Detroit: George S. Davis, 1891. Pp. vi-144. Price 25 cents. The Physician's Leisure Library.

*The Post-Partum Douché* (showing new instrument). By EDWIN PYNCHON, M. D. Read before the Chicago Medical Society.

*Text-Book of Walsham's Surgery.* P. Blackiston Son & Co. *Text-Book of Materia Medica, Pharmacy and Therapeutics.* P. Blackiston Son & Co.

*Text-Book of Foster's Physiology.* Lea Bros. & Co.

*The Comparative Anatomy of the Domesticated Animals.* By CHAUVEAU. D. Appleton & Co.

*A Plea for the Extra-Peritoneal Treatment of the Stump in Abdominal Hysterectomy for Fibroids.* By A. L. SMITH, B. A., M. D., Lecturer on Gynecology, in Bishop's College, etc. Reprinted from *Canada Lancet*, Jan., 1891. Dudley & Burns, Toronto, 1891.

*The Statistics and Lessons of Fifteen Hundred Cases of Refraction.* By GEORGE M. GOULD, M. D., Ophthalmologist to the Phila. Hospital, Phila. Pa. Reprinted from the *Journal of the American Medical Association*, Sept. 19th, 1891.

*The Work of Medicine for the Weal of the World.* By C. H. HUGHES, M. D., of St. Louis, Professor of Neurology, Pathology, and Electro-therapy in the Marion-Sims College of Medicine, St. Louis. Reprint from the *Alienist and Neurologist*, January, 1892, St. Louis.

*Text-Book of Practical Anatomy.* By HENRY C. BOENNING, M. D., Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy, and Demonstrator of Anatomy in the Medico-Chirurgical College, etc. F. A. Davis, Phila., 1891.

*History of the Circumcision from the Earliest Times to the Present; with a History of Eunuchism and Hermaphroditism, etc.* By P. C. REMONDINO, M. D., Vice-President of the Southern California Medical Society, California State Medical Society, etc. F. A. Davis, Phila., 1891.

*Practical Pathology and Morbid Histology.* By DR. HENEAGE GIBBES, Professor of Pathology at the University of Michigan. Lea Bros. & Co., Philadelphia, Pa.

*The Urine; The Common Poisons; and the Milk;* By Dr. J. W. HOLLAND, Philadelphia. P. Blackiston Son & Co., Phila., Pa.

*Quiz-Compend; Physiology.* Dr. Boubaker, Philadelphia. P. Blackiston Son & Co. Philadelphia.

*Hypnotism.* By J. T. Eskridge, Denver, Col. Reprint from *New York Medical Journal*.

We observe with interest the establishment of a daily medical periodical in Philadelphia, entitled "*The Daily Medical News*," edited and published by Joseph F. Edwards, M. D. The subscription price is \$10 a year. It is to contain a condensed daily summary of the medical literature of the world, condensed reports of all State and National Medical Societies and personal items. It will take an unusual outlay of money and energy to make such a journal successful. In certain cities of Europe daily medical sheets are issued, but no successful effort has been made in this line so far in America.

### Medical Progress.

#### SALICYLAMIDE.

This is a synthetic drug prepared by the introduction of the amidogen radicle ( $\text{NH}^2$ ) into salicylic acid. As the presence of this amidogen radicle seems to give a stimulating quality to those therapeutic compounds in which it is found, it would naturally be inferred that salicylamide would be similar in its powers to salicylic acid, but more stimulating. It can be made either by the action of strong ammonia on oleum gaultheriæ, which contains a salicylic compound, or by heating ammonium salicylate. It consists of tasteless, colorless crystals, readily soluble in hot water or alcohol. As stated by Dr. Nesbit (*Therap. Gazette*, Oct., 1891), when given to patients, it—

1. Relieves pain better than salicylic acid.
2. Acts more promptly, and in smaller doses.
3. Is a safer drug.
4. Dissolves more readily in cold water (1 part to 250 parts cold water).

Notes of four cases are given.

Case 1. Female, intense congestive pain in right ovarian region; 5 grains were given every third hour. Relief was obtained after third dose.

Case 2. Boy, Follicular tonsillitis; rheumatic history; pain relieved by a dose of 3 grains; throat clear next day.

Case 3. Severe headache; contracted temporal and facial arteries; relief by 3 grains every hour.

Case 4. Adult female; chronic rheumatism; pain relieved by 5 grains. The heart was here the subject of disease, but no depressing influence was exerted by the drug.

#### MODIFIED OPERATION FOR SQUINT.

The *Ophthalmic Review* states that, at the last session of the British Medical Association, Dr. Argyll Robertson described a method of operating, which he found very satisfactory, and which is briefly as follows:—The internal rectus tendon is seized in Prince's strabismus forceps and separated from the sclera. Its opponent is then tenotomised subconjunctivally. A fine waxed black-silk thread is taken, to either extremity of which a fine curved needle is attached. One of these needles is threaded in and through the base of the tendon, which is pulled forward by Prince's forceps. This, though it seems a weak hold, has in practice proved quite sufficient. One of the needles is now passed in and out, under and over the conjunctiva, close to the upper margin of the cornea, until a point well beyond the outer margin of the cornea is reached. In like manner, the other needle is passed under and over the conjunctiva, close to the lower margin of the cornea, till a corresponding point beyond the outer margin of the cornea is reached. A small bit of the internal rectus tendon (varying in amount according to the effect desired) is then snipped off, the ends of the ligature tightened, until the cornea is well directed inwards, and tied. The edges of the conjunctival incision are brought together by a couple of sutures. Sometimes the traction of the ligature causes the conjunctiva at some points to overlap the margin of the cornea, but this does not interfere in any way with the success of the operation. The ordinary antiseptic washings and dressings are employed. Both eyes are bandaged for twenty-four hours, so as to keep the eyes thoroughly at rest, and the eye operated on for one day longer. On the fourth or fifth day the ligature is removed. This is easily effected by dividing the thread in any part of its course where it lies on

the surface of the conjunctiva, and pulling on the knot, when the whole extent of the ligature at once comes away.

#### THE ACTIVE PRINCIPLE OF WOOD ANEMONE.

Dr. Dupuy, in *Les Nouveaux Remèdes*, July 8, 1891, has extracted, in the form of crystalline needles, a substance from the wood anemone which seems to possess extremely energetic action on the economy. In large doses its toxicity is very marked, producing trembling, hebetude, and sanguinolent diarrhœa, and death from paralysis. From the therapeutic point of view, this drug, which he calls "anemonine," is said to act with great efficiency in catarrh and chronic bronchitis, and especially as a calmative of convulsive cough and in whooping-cough. It is also said to possess emmenagogic properties.—*Therap. Gazette*.

#### HYPODERMATIC INJECTIONS OF SODIUM CHLORIDE IN ANÆMIA.

Weber, (*La Rassegna di Scienze Mediche*), in a grave case of chlorosis with loss of consciousness, anæsthesia, shallow respiration, quick pulse and absence of the pupillary reflex, had recourse to the hypodermatic injection of a sixty per cent. solution of sodium chloride. He injected about three hundred cubic centimeters at one time into the upper and outer third of the thigh, and administered as adjuvants broth, brandy and peptone. Two days after the patient returned to consciousness and passed on to an uneventful convalescence.

Haffter, in a case of acute anæmia following an abortion, injected six hundred grains of a sodium chloride solution of the same strength into the peritoneal cavity. One and a half minutes after the radial pulse was increased in strength. The absorption took place without any reaction.—*Journal of Gynæcology*.

#### POTATO IN RECTUM.

In the *Southern California Practitioner*, October, 1891, Dr. Bullard gives an amusing account of extraction of a "Murphy," 12 inches in circumference(!) from this viscus. The patient was a cook, and his fellows, presumably because he had spoiled their digestion, caught him and rammed the potato into the "other end" of his alimentary canal. The hospital gynæcologist diagnosed transverse position and, under anæsthesia, performed version and applied forceps. No progress was made till a teetotaler present suggested a corkscrew. Craniotomy was performed and this instrument, aided by a large retractor, pressed against the posterior wall of the rectum, finally, after many slips, accomplished delivery, without even a scratch on the perineum. After two days confinement the patient left the hospital whole.

#### WHAT MODERN THERAPEUTICS MAY LEAD TO.

"The fertility of the therapist's brain, the child-like simplicity of his faith, and the perpetuity of his apian industry and perseverance amid failures and disappointments, were amply illustrated at the Tubercle Congress held in Paris. No sooner is an animal found to be immune against a certain disease to which man is susceptible, than an attempt is forthwith made to transfer its nature by blood transfusion; and in the future, when Dr. Chien's patients, who have been made watchful and servile by having their blood diluted with dog's blood serum, and those of Dr. Geiss, who fills their veins with goat's blood, which renders them agile and obscene, yet dignified and venerable-looking, meet on the highway the pompous, arrogant and inflated patients of Dr. Cock, who, fed on rooster salad, grow fat and sleek, together with those of Drs. Asinus and Morueco, there will be such a barking, bleating, braying and crowing as was never heard in the world's

history since the disembarkation of the animals after the stranding of Noah's ark."

This clipping from the editorial columns of the *Pacific Medical Journal* has a flavor which suggests the age of Jenner and the Anti-vaccinationists.

#### SACRAL RESECTION IN GYNECOLOGY.

In a paper before the American Association of Obstetricians and Gynæcologists, at its recent session in New York, Dr. Montgomery (*American Gynecological Journal*, October, 1891) advocated this procedure in the following conditions:—Malignant disease of both rectum and uterus; cancer of the uterus with uterine enlargement, or when the vagina was small and the case complicated by disease of the tubes and ovaries, causing extensive adhesions.

Operation—The patient being upon the left side or in the semi-prone position, a bow-shaped incision is made, extending from the right sacro-iliac chondrosis, across the median line to a little beyond the apex of the coccyx. Having enucleated the coccyx he separates ligaments and muscles from the right side of the sacral foramen, cuts off with chain saw or bone pliers the right ala of the sacrum.

For removal of the uterus and appendages, the rectum is pushed to the left and the peritoneal cavity entered. The posterior surface of the uterus is then exposed, when the broad ligaments may be seized, raised up, and ligated and the uterus removed. After removing the uterus, the peritoneum may be stitched over the vagina and the posterior peritoneal opening also closed.

He prefers vaginal hysterectomy to this operation where the conditions are favorable for the former.

He had performed this operation in two cases; one for cancer of the rectum and the uterus, where three inches of the rectum and the uterus and appendages were removed, and the calibre of the gut restored. A secondary operation, four weeks later, was made necessary by a large mass of feces pushing off the lower segments of the rectum.

The second case was one of cancer of the uterus complicated with tubal and ovarian disease with adhesions.

Both patients recovered and subsequently suffered no inconvenience in locomotion.

The paper gave rise to much discussion, some members advocating the new measure, some condemning it.

#### INFLUENCE OF CHLORAL ON THE CIRCULATION.

From experiments in the laboratory on dogs, Dr. Cerna, writing in the *University Medical Magazine*, November, 1891, arrives at the following conclusions—conclusions which apply only to dogs (so far as the pulse and blood-pressure in animals are concerned), these being the animals used exclusively in this part of the investigation:

I.—When locally applied, chloral is a powerful heart-poison.

II.—The drug diminishes greatly, and, in sufficiently large quantities, destroys completely the electro-excitability of the cardiac muscle.

III.—Chloral is a treacherous drug, sometimes producing a sudden paralysis of the heart.

IV.—The drug diminishes the frequency of the pulse by a double action. It influences the heart itself, and likewise stimulates the cardio-inhibitory nerve-centres.

V.—The slight rise sometimes observed in the arterial pressure is secondary to changes in the respiration. Chloral causes a fall of pressure mainly by acting



upon the heart, and probably also by influencing the pneumogastric centres through the vagi and by paralyzing the muscle-coats of the arterioles.

MORPHIA IN PREGNANT, PARTURIENT AND NURSING WOMEN.

Furst (*Archives de Obstetrique et de Gynecologie*) gives the results of his studies to determine the effect upon the foetus when morphia has been administered to the mother. In one case 1,200 hypodermic injections of a three per cent. solution of morphia had been taken during pregnancy, and in a later gestation 800 injections of the same strength. Before labor the foetus was quiet after the drug was given to the mother until its effect began to wear off, when foetal movements were very active. After birth the children manifested no signs of physical or intellectual development. Furst concludes from this and other observations that morphia does not endanger foetal life to so great an extent as has been thought. Used moderately it is not a dangerous drug for pregnant women. Its usefulness in threatened abortion and miscarriage is well known. During labor, particularly when prolonged, its use is more dangerous. He notes the rapid passage of the drug into the milk when given to the nursing mothers.

WICKERSHEIMER PRESERVATIVE FLUID.

This preparation is made as follows:

R.—Alum . . . . .	100 parts.	
Salt . . . . .	25 parts.	
Saltpetre . . . . .	12 parts.	
Potash . . . . .	60 parts.	
Arsenious acid . . . . .	10 parts.	
Boiling water . . . . .	3,000 parts.	—M.

After dissolving, cool and filter.

To ten parts of this solution are added four parts of glycerine and one of methyl alcohol. If preparations are to be preserved dry, they should be soaked in the fluid for from six to twelve days, according to their size, and dried without heat.

FOWLER'S SOLUTION FOR THE CURE OF WARTS.

Dr. Müller, of Hamburg, recommends Fowler's solution for the removal of these unsightly objects. He states that he has had uniformly good results with it. His practice is to commence in adults with two drops thrice daily, with children half a drop for a dose. The dose is to be increased week by week. The cure generally follows in from two to three weeks, the warts disappearing gradually and almost imperceptibly.

A NEW USE FOR THE CIGAR.

A most impressive bit of testimony to the value of tobacco-smoking in relaxing that rigidity of the cervix uteri, which is in certain cases of parturition such a painful and perilous hindrance to the progress of the labor, is given by Dr. Bird in the *Medical Bulletin*, November, 1891. The rigidity of the cervix, in a multipara under his care, resisted copious blood-letting and nauseating doses of antimony, but yielded readily to the smoking of a pipeful of tobacco. Since this experience, Dr. Bird has employed tobacco frequently in such emergencies. Many of his patients now, in making up the "basket" for labor, place a couple of good cigars in it. After labor has once set in one or two cigars will facilitate not only the dilatation of the cervix, but also the relaxation of the perineum, preventing tears in that important structure and the prevarication on the part of the obstetrician which so often follows. The vision of "the woman of the

twentieth century" reclining on what now is feared as the "couch of agony" with a half dozen good cigars at hand, amusing herself during the stages of labor in sending smoke-rings heavenward, is really almost too beautiful to be true. Still the method deserves trial in appropriate cases. The aid which smoking lends in hastening defecation is well known to all who enjoy the after-dinner cigar.

#### DIAGNOSIS BETWEEN MYALGIA LUMBALIS AND LUMBAR SPRAIN.

In the *University Medical Magazine*, November, 1891, Dr. Latta tabulates the points of difference as follows:

##### *Myalgia Lumbalis.*

Duration five to ten days.

Onset sudden.

Cause: Predisposition; rheumatic or gouty diathesis; exposure to cold and wet; over-fatigue or slight strain of muscles in one having a predisposition.

Pain: tearing or aching; confined to a single or group of muscles; aggravated by movement.

No outward signs.

Rarely painful to touch; pinching affected muscle may elicit pain.

No particular decubitus.

Heat aggravates.

Constitutional symptoms not common.

##### *Lumbar Sprain.*

Duration, fourteen to twenty-eight days.

Onset instantaneous.

Cause: Injury by twist, fall, direct force or from overlifting.

Pain: Acute, lancinating and diffused; slight movement causes agony.

Local heat; swelling, ecchymosis and discoloration.

Excessive local tenderness.

Decubitus on *either* side, with knees drawn up toward chin.

Heat is grateful.

Constitutional symptoms nearly always present.

#### INCOMPATIBILITY OF IODIDE OF POTASSIUM AND CHLORATE OF POTASSIUM.

According to M. Sohet, the combination of these two much-used drugs in solution gives rise to the iodate of potassium, which is very poisonous. It is stated that many years ago M. Melsens learned by experiment that a solution containing about ten grains each of the above-named salts was powerful enough to cause the death of animals.

#### THE TREATMENT OF BROMISM.

Féré some time ago advised intestinal antiseptics in endeavoring to counteract the unpleasant effects of the long-continued use of the bromides. According to the *Bollettino della Poliambulanza di Milano*, he has recently made a second communication on the subject. He employs *b*-naphthol combined with salicylate of bismuth. Sixty grains of the former and thirty grains of the latter drug are given daily. Thanks to this antiseptics, he is enabled not only to continue the use of the bromides, but to increase the dose up to two hundred and even two hundred and fifty grains a day. The treatment is especially effective in causing the disappearance of the cutaneous manifestations of bromism. Since borax has come into use in the treatment of epilepsy, Féré has noticed that it also often caused unpleasant disturbances of the skin. He has therefore employed the same method of intestinal antiseptics, and found it equally successful. He suggests

that further experimentation may show that intestinal antiseptics will permit of the employment of many other drugs which at present are not well borne by the system.—*N. Y. Medical Journal*.

#### A MEDICAL CENTENARIAN.

The death is reported at Bordeaux of Dr. Stanislas Zalewski, a Polish refugee. Born in 1780, on Christmas Day, he had consequently at his death almost reached his 111th year. This veteran was a scion of the once powerful house of Zalewski, whose estates were confiscated by the Russian Government. Banished from his native land, Dr. Zalewski practised medicine for a long series of years at Bordeaux; thirty years ago, however, the encroachments of old age compelled him to resign practice. Since his retirement he had subsisted on a very modest pension allowed him by the government of his adopted country. His historical *souvenirs* were, as might be expected, most interesting, reaching back to the tragic events that marked the close of the last and the early part of the present century. Thus, he saw Napoleon the First reviewing his army at Moscow; and, peering timidly through a window and nestling against his weeping mother, he was a witness of the execution of Louis XVI. Until quite recently this relic of a past age enjoyed good health, and his faculties are said to have remained unimpaired to the last.—*Lancet*.

#### BEWARE OF THE FREE USE OF COCAINE IN HAY FEVER.

Dr. Joseph William Stickler, of Orange, N. J., writes to *New York Medical Journal*: "I say beware for the following reasons:

1. It may cause a very great, even dangerous, depression of the vital powers. Last summer a patient introduced quite a liberal quantity into his nostrils, and in a few moments he was in a condition of collapse. His physician was sent for, and, after working over him for a long time, had the pleasure of seeing him restored to a speaking condition. Subsequently a good deal of professional care was required to bring him up to anything like a normal state of health.

2. If used freely it seriously impairs the appetite.

3. If used late in the day or during the evening it is very apt to induce insomnia. Persons who have hay fever do not long for any other physical disaster, at least not till they get rid of the sneezing.

4. The free use of cocaine induces in many persons a free diaphoresis. I have known the drug to act so energetically as a "sweater" as to exhaust the patient's strength.

5. The excessive use of cocaine often causes troublesome congestion of the nasal mucous membrane.

6. This powerful drug prevents sneezing and allays irritation only when the membrane affected is under its anæsthetic influence; hence in bad cases it must be used almost constantly.

7. Cocaine causes in some persons a very pleasant mental stimulation, which, while it lasts, is very delightful, but is invariably followed by mental depression and often by great irritability of temper.

8. It often causes troublesome constipation.

9. It does not cure hay fever."

#### THE CURE OF CHRONIC PERITONITIS BY LAPAROTOMY.

Henoch (*Berliner klin. Wochenschr.*, July 13, 1891), presented to the Society of Physicians of the Charité, at Berlin, the case of a girl five years old, who, following a fall, developed considerable ascites. Not yielding to thrice-made puncture, laparotomy was performed. On opening the abdominal cavity, the peritoneum was found not only reddened and thickened, but covered with innumer-

able grayish-red miliary nodules. Carefully examined microscopically, the nodules presented nothing tuberculous in character. The child recovered perfectly.—*Med. News.*

#### DR. KOCH'S TUBERCULIN.

A telegram from our Berlin correspondent, which we receive when going to press, informs us that Dr. Koch publishes in the *Deutsche medizinische Wochenschrift*, on October 22nd, a further communication on tuberculin, from which it results that, by adding to tuberculin alcohol of 60 per cent., a deposit is formed, which Koch considers to be as nearly as possible the active principle of tuberculin. In therapeutic action this purified tuberculin does not differ materially from the original preparation. It will be interesting to compare the text of this communication with the details of the important results achieved by the research of Dr. William Hunter—published in the *British Medical Journal* of July 25th—and the clinical applications of it by Mr. Watson Cheyne. It will be remembered that Koch had at first regarded the active properties of tuberculin as being connected with one body whose nature he did not know, except that it readily passed through parchment—that is, it dialysed readily. The other constituents of tuberculin were harmless, he considered, in their action. Hunter found that the two most characteristic effects of tuberculin—fever and inflammation—were due to two separable substances, each of which could be made to act independently. In respect to the dialysable character of the substances, his conclusions showed new results. He succeeded in obtaining a substance which would have the healing effect of tuberculin without inflammation.—*Brit. Med. Jour.* October 24, 1891.

#### NEURALGIA.

Dr. W. M. Hightower recommends the following:

R<sub>x</sub>—Ammonii bromidi,  
 Sodii salicylatis . . . . . āā ʒ j.  
 Tincturæ hyoseyami . . . . . ʒ ij.  
 Aquæ ad . . . . . ʒ iv.

Sig.—One teaspoonful every half-hour until relief is obtained, or four doses have been taken.—*Memphis Medical Monthly.*

#### TREATMENT OF STYE.

At the commencement, as soon as the irritation is felt, apply compresses dipped in a three or four per cent. aqueous solution of boric acid. After several hours, carefully wash the borders of the affected lid with the same solution by means of a pledget of absorbent cotton dipped in the fluid. During the night apply compresses wet with boric acid, or a cataplasm of potato starch made up with the acid solution. The next morning a white spot will show itself in the center of the little tumor. This should be incised with a sharp, thin lancet, and the compresses again used. A solution of corrosive sublimate, one part in 5,000 of water, may be used instead of the boric solution.—*British and Colonial Druggist.*

#### TREATMENT OF MIGRAINE.

In the *Archiv für Psychiatrie*, Band xxi, Heft 1, Dr. Neftel has a paper on this subject, of which an abstract appears in the *Neurologisches Centralblatt*. He regards the condition as a vaso-motor neurosis, but has nothing new to say about the etiology. As to treatment between the attacks, the circulation must be carefully attended to and kept active. Constipation must be got rid of, which is best effected by the use of diminishing doses of mineral waters and by the use of

electricity to the abdomen. Muscular exercise must also be prescribed, and subsequent temporary rest, and nothing should be eaten or drunk until at least half an hour later. Then a cup of freshly boiled water, he says, will be found wonderfully refreshing. The systematic use of electricity to the head is strongly recommended, and Dr. Neffel finds that in some cases the constant current, in others the interrupted, is beneficial. For the attacks themselves electricity also is recommended, together with ergotin for plethoric patients and salicylate of soda for anæmic sufferers, or a large dose of quinine for either class.—*Lancet*.

#### TREATMENT OF OLD ULCERS OF THE LEG.

Dr. Charles P. Elwert, of New York, writes to the *Medical Record*: "I have treated in the past six months, at Demilt, Bellevue, and Vanderbilt Dispensaries, and also in my private practice, forty-six cases of varicose and other ulcers of the leg, and have obtained favorable results in thirty-four cases by the following method. Cleanse the ulcer by irrigating with a solution of corrosive sublimate, 1 to 5,000. Then dry thoroughly with absorbent cotton, and apply daily the following powder:

℞.—Iodoform . . . . . ʒss.  
 Sulphate of cinchonidia . . . . . ʒj.  
 Wood charcoal . . . . . ʒijss.

If any discharge appears after applying the powder, use absorbent cotton before applying the powder again. Advise the patient to rest and to keep the leg elevated. Keep the bowels regular with a mild laxative, and give some stimulating tonic to improve the condition of the general system. In the case of my four patients the powder caused irritation, and the discharge was increased. On further examination of those patients I discovered the existence of Bright's disease. In six other cases, where the above treatment was not successful, a poultice composed of powdered wood charcoal and matricaria was used for three or four days, until I obtained a healthy appearing surface to the ulcer; and I then applied daily the following solution:

℞.—Tr. calendulæ . . . . . ʒij.  
 Aquæ camphoræ . . . . . ʒviiij.

After applying the solution, I strapped the ulcer with adhesive plaster, with good results in four of the above six cases, and gave laxatives and a tonic. As the treatment of chronic ulcers at the present day is not very successful in a large percentage of cases, especially in dispensary practice, the above treatment may be of use to the profession."

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#### Medical Items.

Professor Bartholow directs in muscular rheumatism that milk and all saccharine substances be excluded from the diet.

At the last meeting of the British Medical Association, Dr. Ferdinands declared, as the result of his investigations among school children in Aberdeenshire, that in a total of 3,000, 13.4 per cent. were myopic and 16.5 per cent. hyperopic.

The Secretary of the Iowa State Board of Health has made an official announcement that habitual inebriety on the part of a medical practitioner shall be held as "palpable evidence of incapacity," rendering the delinquent liable to the revocation of the certificate entitling him to practise in the State of Iowa.

According to an item in the *Pacific Med. Jour.*, Dr. John M. Keating, of Philadelphia, who has been spending the summer at Colorado Springs for his health, has decided to locate there permanently. He will limit his practice to diseases of women and children, in which as a practitioner, writer and teacher, he has won not only national, but world-wide fame.

Alex. J. C. Skene, M. D., has been notified of his election as Corresponding Member of the Société Royale des Sciences Medicales et Naturelles of Brussels. This honor was conferred on the recommendation of a special committee, after a thorough examination of his contributions to medical literature.

The first lady admitted to the medical profession in Portugal completed her curriculum in the Lisbon Medico-Chirurgical School last year. This year two ladies, Senora D. Amelia Cardia and Senora D. Sophia da Cunha, have taken the degree of Doctor of Medicine in the same seat of learning, and two others have just finished their medical studies at Oporto.

We learn that on October 9, Professor W. W. Keen, of Philadelphia, removed from a patient a considerable portion of the right lobe of the liver for the excision of a cystic tumor, the entire mass taken away being about two-thirds the size of a man's fist. The woman's temperature has remained normal, or nearly so, since the operation, rising only once to 100° F. There seems every reason to believe that the patient will recover.

Bryant's advice to a young contributor—says the *California Druggist*—is worth starting on a new round of usefulness. "I observe," wrote he, "that you have used several French expressions in your letter. I think if you will study the English language that you will find it capable of expressing all the ideas you may have. I have always found it so, and in all that I have written, I do not recall an instance where I was tempted to use a foreign word, but that on searching, I have found a better one in my own language. Be simple, unaffected; be honest in your speaking and writing. Never use a long word where a short one will do as well. Call a spade by its name, and not a well-known instrument of manual labor; let a home be a home, and not a residence; a place, not a locality; and so on of the rest. When a short word will do, you will always lose by using a long one.

An instrument for optical comparison of transparent liquids, a "liquoscope," was recently devised by M. Sonden of Stockholm. Two hollow prisms holding the liquids are separated by a partition at right angles to the refracting angle. The whole is placed in a vessel filled with glycerine, and which allows of vision in a horizontal direction through plane glass plates. The deflection of the light rays through the prisms is thus compensated. So long as the two liquids have the same optical action, one sees a distinct mark (say a black paper strip on a window) as a straight connected line; but its halves are relatively displaced if the liquids have different refractive powers. The amount of displacement gives a measure of the difference, the positive or negative nature of which also appears from the direction of displacement. The author recommends his apparatus for chemical purposes, especially comparison and testing of fats and oils, analysis of glycerine, etc., and detection of margarine in butter, margarine greatly lowering the index of refraction,

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NO. 555

## CONTENTS

### ORIGINAL ARTICLES.

Some Considerations Concerning Antiseptic Surgery. By Wm. H. Welch, M. D., Baltimore. 45

### EDITORIAL.

Semi Annual Meeting of the Medical and Chirurgical Faculty of Maryland. . . . . 58

University Extension. . . . . 59

The Roller Bandage for Pains of Spine Disease. 59

Legitimate Pharmacy. . . . . 60

### MEDICAL PROGRESS.

Therapeutic Effect of Diuretin.—Phlegmasia Dolens.—Cannabis Indica.—Some of the Newer Hypnotics—Pharyngitis.—Europhen.—Inflammation of the Prostate. . . . . 61

### OBITUARY.

Dr. Thomas B. Evans and Dr. T. Barton Brune. 65

### MEDICAL ITEMS.

. . . . . 66

## Original Articles.

### SOME CONSIDERATIONS CONCERNING ANTISEPTIC SURGERY.\*

BY WILLIAM H. WELCH, M. D.,

Professor of Pathology, Johns Hopkins University.

The greatest achievement of modern surgery is not so much the triumph of abdominal or of cerebral surgery, or of any particular class of operations, as it is the method which has brought into the surgeon's domain every organ of the human body. The victories of this method are manifested not less in the aseptic healing of the wound resulting from the removal of a simple wen, than in the recovery without suppuration and fever after the extirpation of a cerebral tumor, or of a large abdominal tumor.

Modern surgery begins with the introduction of antiseptic methods of wound treatment, and it is the imperishable merit of Lister to have ushered in this era by his recognition of the great truth that the infection of wounds depends upon the presence of bacteria and by his adoption of measures of treatment based upon this truth. Upon the establishment of these fundamental principles his fame will rest, even if every detail in his original method of treatment be replaced by means found better suited to the purpose.

No apology is needed if a pathologist ventures to speak to you about a subject with such practical bearings as surgical antiseptics, when it is recalled that antiseptic and aseptic methods of wound treatment rest upon bacteriological work no less than upon clinical experience. In the development of these methods the surgeon and the bacteriologist have worked hand in hand. The harmony and

\*A talk before the Clinical Society of Maryland, on October 13th, 1891. The address was delivered extemporaneously and this paper is from the stenographer's report, revised by the author.

co-operation between the worker in the laboratory and the practical physician and surgeon have never been so great as at the present time. On the one hand, the experimenter applies himself to problems of immediate interest to the practitioner and seeks the aid of clinical observation as never before, and the practitioner is eager to learn and to apply the established results of experiment. That this combined work is calculated to advance scientific and practical medicine in the surest way cannot be doubted.

Lister's original antiseptic methods, which were introduced about the middle of the sixth decade of this century, were founded mainly upon the views which prevailed at that time as to the relation of bacteria to the processes of putrefaction and fermentation. One chief source of the bacteria which infect wounds was regarded as the air; and by the use of carbolic acid spray he hoped to disinfect the air over the field of operation. Lister also employed carbolic acid as the agent for disinfecting the wound, hands, instruments and all that might come in contact with the wound. The dressings applied to the wound were permeated with the disinfectant and were expensive and somewhat complicated. The method necessitated extensive use of drainage tubes and frequent change of dressings.

The results of this method marked a great advance in surgery, the contrast between the new and the old method being more evident in Germany than in Great Britain, because in the former the hospitals were, in general, older, less cleanly and in a less sanitary condition. Good as were the results of the new method, they were still so far from perfect that efforts continued to be made to improve the method.

It is evidence of the value and fructifying influence of the new ideas introduced by Lister that they have proven capable of wide development; that they have stimulated workers in science and in practical medicine to efforts which have extended our knowledge far beyond the mark of a quarter of a century ago; and that they have occasioned unprecedented activity and progress in surgery during this period. Permit me to direct your attention to some of these advances in the general principles of antiseptic surgery, looking at the subject rather from the point of view of the bacteriologist than from that of the practical surgeon. In the limits of a paper of this kind it is possible to select for consideration only a few points, leaving many of great importance untouched.

The most fundamental advance relates to the extension of our knowledge concerning the nature and habits of the micro-organisms which cause traumatic infections. As has already been said, Lister's early work was based upon analogies drawn from the relation of bacteria to the processes of fermentation and putrefaction. Nothing or almost nothing was known as to the bacteria actually concerned in suppuration and other wound infections. The observations of Klebs, Recklinghausen and others at this period concerning the presence of micrococci in pyæmia and other suppurative conditions gave little information as to the character and behavior of these organisms.

The new era in bacteriology was introduced by the publication of Robert Koch's *Untersuchungen über die Aetiologie der Wundinfektionskrankheiten*, in 1878. The kind of evidence necessary to prove the causation of a disease by a specific micro-organism was here clearly set forth and was brilliantly illustrated by his study of a number of new infectious diseases, chiefly experimental septicæmias, produced in mice and rabbits by the inoculation of foul substances. Three years later, Koch gave to the world the details of his method of cultivating bacteria upon solid transparent media, without which most of the great discoveries in bacteriology during the last decade could not have been made.



Although Koch's epoch-making publication was entitled *Investigations Concerning the Etiology of Traumatic Infections*, this did not relate to the bacteria which cause wound infections in human beings; and it was hardly less misleading when inferences were drawn as to the nature and mode of causation of suppurative and other traumatic infections of human beings from supposed analogies with Koch's experimental septicæmias, than from those with fermentation and putrefaction.

The first thorough study by modern bacteriological methods of the bacteria causing suppuration in human beings was made by Ogston, Rosenbach and Passet, between the years 1880 and 1885. To this period belongs also the study and first cultivation of the erysipelas coccus by Fehleisen. Ogston confined his attention to the microscopical observation, by the improved optical aids, of the staphylococci and streptococci of suppuration. The other investigators isolated in pure culture and studied the different species of bacteria found in abscesses. These fundamental researches made us familiar with the ordinary pyogenic staphylococci and streptococci. Now, for the first time, the causation of the most common, and, therefore, the most important, of all traumatic infections, namely, the suppurative, could be satisfactorily studied. The commonest enemies of the surgeon were known, their distribution in nature, the ways in which they may gain entrance to wounds, their habits and behavior both inside and outside of the body, were open to direct observation and experiment. It could not be doubted that this increased knowledge would lead to more efficient means of combatting the enemy, and this has proven true.

Although we have learned that many other species of micro-organisms than those originally described by Ogston, Rosenbach and Passet may be concerned in traumatic infections of human beings, nevertheless the pyogenic cocci are by far the most common and important, and these are the ones which have been most thoroughly studied. It soon became evident that the study of infection with the pyogenic cocci presents many peculiar and complicated problems; and we owe especially to Grawitz and his pupils the demonstration that under ordinary conditions, the healthy tissues in many situations are capable of disposing of a large number of these cocci without manifest injury, and also the recognition of several abnormal conditions which deprive the tissues of this power.

It is becoming every day clearer that the most valuable friend which the surgeon has in his efforts to secure aseptic healing of his wounds is the capacity of the fluids and cells of the animal body to overcome invading micro-organisms. The indication is no less urgent than ever before to keep bacteria out of wounds in every way possible, but it seems plain that hitherto the efforts of the antiseptic surgeon have been directed too exclusively toward this indication and toward the attempted destruction of bacteria which may have accidentally entered the wound, and not enough toward preserving, as far as possible, the germicidal power of the tissues and fluids.

Among the influences which have been found favorable to the growth in wounds of bacteria, which otherwise might be disposed of by the tissues and animal fluids without harm, are the presence of foreign bodies, such as drainage tubes and coarse ligatures, the necrosis and degeneration of tissue caused by the contact of strong chemical disinfectants with the wounded tissues, the strangulation of masses of tissue with ligatures, the strangulation, tension and interference with the circulation often caused by deep coaptation sutures, and interference with the circulation and vitality of tissues which may result from too forcible pressure. If it were within the power of the surgeon to keep bacteria entirely

out of wounds, or to destroy them without damage to the tissues after they enter, the conditions just mentioned could not by themselves alone cause infection, but this power he does not at present possess, as is demonstrated by the bacteriological examination of wounds treated aseptically or antiseptically. Hence it behooves him to learn all that he can concerning those conditions which favor and those which are hostile to the development of bacteria in wounds, and to endeavor to retain and produce the hostile and to remove the favorable conditions for the growth of bacteria.

That conditions predisposing to suppurative and septic complications of wounds are to be sought not only in local conditions about the wound, but also in the general state of the patient, is known to every surgeon of experience, and this latter side of the subject has been recently presented in an interesting and suggestive manner by Dr. Roswell Park, in his paper before the Congress of American Physicians and Surgeons.

It has been a stumbling block in the way of the acceptance of the general principles of antiseptic surgery by some, that surgeons who claim to disregard these principles have good results even in operations which were considered unwarrantable before the introduction of antiseptic methods. The foremost champion of these dissenters is, perhaps, Lawson Tait, so widely known as a successful laparotomist. But there is no difficulty in explaining these results, which in reality furnish no sound argument against the employment of proper antiseptic measures in the treatment of wounds. Mr. Tait and his followers make extensive, although not sufficient, use of the most efficient of all antiseptic agents, namely, heat. By attention to cleanliness they greatly diminish the chances of infection of wounds by bacteria. They are often particularly rapid and skillful operators. Above all they respect the vitality of the tissues, especially by withholding the application to them of chemical disinfectants. They do not disregard the principles of antiseptic surgery to the extent that they may suppose they do, but they would be wiser if they paid still more attention to these principles. Because the use of unsterilized ligatures or the washing of the peritoneal cavity with unsterilized water is not attended by bad results in many cases, is no proof that it is not safer to sterilize ligatures and all that comes into contact with a wound.

Moreover, there are special reasons, now well known, why the results of operations in the peritoneal cavity cannot be regarded as the best test of antiseptic methods. The healthy peritoneum is tolerant to an extraordinary degree of the presence of pyogenic bacteria, but when these conditions of tolerance are overstepped then the dangers from infection surpass those from infections of wounds of external parts. These exceptional dangers are what render the employment of proper antiseptic measures especially imperative in laparotomies.

The tendency at the present time to abandon the application of strong disinfectant solutions to fresh wounds and to pay more attention to the gentle handling of wounded tissues has been interpreted by some as a reaction against antiseptic surgery and a return to ideas which obtained in pre-antiseptic days. It is true that the capacity of the living tissues to resist putrefaction and the influence upon the process of healing of the character and condition of wounds are very old conceptions in surgery. The old books on surgery have much to say on these points, and entered into extreme refinements in the classification and description of wounds, with especial reference to their behavior in the process of repair. They contained much sound doctrine in these matters, which can still be perused with profit. But the results of the old and those of the new surgery are

alone sufficient to prove the wide difference between them. Under the old regime the healing of wounds without suppuration was so exceptional that the occurrence could even be disputed by prominent surgeons, whereas now the surgeon with good technique may look with reasonable certainty to this result, once so exceptional. The foundations of antiseptic surgery are strengthened, not shaken, by improvements in details and by the recognition of new principles. Now that we recognize the dangers of applying strong antiseptic substances to wounds and the difficulties of disinfecting wounds in this way, the arguments are stronger than ever before for operating with as nearly sterile surroundings as possible and for keeping the wound from contact with unsterilized objects.

Permit me to say in this connection that I fail to see the advantage of using the term aseptic surgery in the sense in which it is generally employed at the present time as something distinct from antiseptic surgery. One hears on all sides such expressions as that aseptic surgery is displacing or is destined to displace antiseptic surgery. What is understood by aseptic surgery undoubtedly marks an important advance in surgical antisepsis, but it is none the less antiseptic surgery. It would seem as if some supposed that antiseptic surgery means nothing more than the use of chemical disinfectants in the management of wounds, or that antiseptic technique is incapable of improvement. An antiseptic agent is anything which has the power of arresting the development of septic bacteria. With his views as to the influence of blood in a wound in favoring infection, von Bergmann has said that a ligature is one of our most important antiseptic agents. The substitution of heat for chemical substances in the disinfection of instruments, ligatures, dressings, etc., is an important advance but it is only the substitution of a more powerful for a weaker antiseptic agent. The object of antiseptic surgery is to secure an aseptic condition of a wound, and here it may be well to remark that this rarely is equivalent to the condition generally understood in a bacteriological laboratory as aseptic, namely, freedom from bacteria.

The abandonment of disinfectant applications to a wound is for the purpose of securing the action of more efficient antiseptic agencies under the circumstances, namely, the fluids and cells of the surrounding tissues, and this abandonment renders all the more urgent the use of antiseptic agents outside of the wound. It is doubtless one of most useless occupations to contend against current usage in medical nomenclature, but it seems to me unfortunate that the term aseptic surgery should be introduced as if it signified something different from antiseptic surgery and not simply an improvement in the methods of antiseptic surgery.

It is interesting from a bacteriological point of view to note the improvement in the dressing and management of wounds since the pioneer work of Lister. The early efforts in this direction, especially in Germany, were to render the dressings less expensive and less cumbersome, items of no small consideration in a hospital with limited resources. Important advances in principle, however, resulted from the efforts to do away with the frequent changing of surgical dressings, which was necessitated by Lister's early method. The employment of absorbent material for the dressings without the outside impermeable covering adopted by Lister, permits rapid drying of the secretions and, therefore, rests upon the sound basis that bacteria find in moist media opportunities for their growth not furnished by dry material. Every bacteriologist knows that his culture tubes are much more likely to become contaminated if he places a rubber cup over the cotton-wool at the mouth of the tube than without this precaution, unless he takes especial pains to sterilize the cotton-wool and the mouth of the tube before applying the

rubber. It is almost impossible for the surgeon to keep his dressings for any length of time free from bacteria, and it is, therefore, advisable not to shut these bacteria into secretions and an atmosphere saturated with moisture, prevented, by an impermeable covering, from evaporation.

Some of the most important advances in antiseptic surgery have come from the efforts to dispense with the use of drainage tubes. The drainage tube question is a part of the much larger one: How shall the so-called dead spaces, that is, the cavities and recesses, in a wound be managed? The surgeon has at his disposal the choice between many various means for managing these spaces. He can drain the spaces, or stuff them with foreign material, or endeavor to obliterate them by pressure, or by buried sutures, or by inverting sutures, or by transplantation of flaps, or he can permit them to fill with blood, or he can let them alone. Doubtless no one of these methods is universally applicable; probably each one has its field of usefulness. The skill of the surgeon consists in large measure in the manner in which he exercises his judgment as to the management of the dead spaces in a wound, and I shall venture to say a few words on this important but still unsettled question only from a bacteriological point of view.

The following objections to the insertion of drainage tubes into wounds suggest themselves: *First.* They tend to remove bacteria which may get into a wound from the bactericidal influence of the tissues and animal juices. *Second.* Bacteria may travel by continuous growth or in other ways down the sides of a drainage tube and so penetrate into a wound which they otherwise would not enter. We have repeatedly been able to demonstrate this mode of entrance into a wound of the white staphylococcus found so commonly in the epidermis. The danger of leaving any part of a drainage tube exposed to the air is too evident to require mention. *Third.* The changing of dressing necessitated by the presence of drainage tubes increases in proportion to its frequency the chances of accidental infection. *Fourth.* The drainage tube keeps asunder tissues which might otherwise immediately unite. *Fifth.* Its presence as a foreign body is an irritant and increases exudation. *Sixth.* The withdrawal of tubes left any considerable time in wounds breaks up forming granulations and thus both prolongs the process of repair and opens the way for infection. Granulation tissue is an obstacle to the invasion of pathogenic bacteria from the surface, as has been proven by experiment. *Seventh.* After removal of the tube there is left a tract prone to suppurate and often slow in healing.

The advantage from the employment of drainage tubes is, of course, the removal of secretions, and this indication becomes an urgent one if the cavity with which the tube communicates becomes infected and suppurates. In a given case the surgeon must weigh the advantages and the disadvantages and act according to his judgment. The practice of many surgeons at the present time, of restricting within much narrower limits than formerly the use of drainage tubes and of discarding them for all wounds which offer a fair prospect of primary union, is a distinct advance in the technique of antiseptic surgery.

The practice of stuffing cavities with foreign substances, even those of an absorbable nature, is open to most of the objections already urged against drainage tubes.

Much can be accomplished by external pressure in bringing together the surfaces within a wound, but this procedure is of only limited application, for on the one hand only such spaces can be obliterated in this way as are favorably situated and have surfaces suitable for coaptation, and on the other hand there is difficulty in regulating the pressure so that it does not interfere with the circulation and with the vitality of the tissues.

The method elaborated especially by Neuber and by Küster, of obliterating spaces in a wound by means of deep coaptation sutures, has unquestionably given excellent results, but it is not free from serious objections. The conscientious execution of the method often is tedious and greatly prolongs the operation, and it may be doubted whether the object aimed at is not often missed. The most manifest objections however, are the presence in the wound of so many foreign bodies in the form of sutures as are often required, and especially the danger of strangulating and stretching unduly the tissues, and thus interfering with their anti-bacterial capacities. The thinner the sutures employed, the smaller is the danger of their presence as foreign bodies.

The idea that blood in a wound is a dangerous thing is a prevalent one, and such surgeons as Küster and von Bergmann in recent years have dwelt especially upon this danger. Blood is looked upon as a foreign substance more dangerous than most foreign substances because it is held to be especially prone to decomposition by bacteria. Nevertheless, John Hunter was fond of dwelling upon what he called the vitality of blood, and was acquainted with its so-called organization in wounds. Mr. John Chiene, about fifteen years ago, directed attention anew to the same views; but it was Schede who in 1886, in an article on the Healing of Wounds Under the Moist Blood Scab, brought prominently to the notice of surgeons the value of the blood clot in the healing of a certain class of wounds. The discoveries more recently made as to the power of fresh blood outside of the body to destroy many kinds of bacteria (although in only very limited degree the pyogenic cocci) or their poisonous products have shed additional light upon this subject. The credit of introducing as a method of general applicability the management of dead spaces by permitting them to fill with blood belongs to Halsted. Before him several surgeons, and Schede especially, had recommended the use of the blood clot for a limited class of wounds and for a limited purpose, but Halsted has substituted for all other methods previously employed in treating dead spaces not otherwise easily obliterated, that is, for drainage tubes, buried sutures, pressure, etc., the use of the blood clot as the method of widest applicability and as affording the best results. In a paper read before the recent Congress of American Physicians and Surgeons, I described the results of my experiments on animals, which supported the conclusions derived from clinical experience as to the value of the method of healing of wounds by allowing spaces to fill with blood. That the unintended presence of blood in a wound may be a source of danger by occasioning undue tension and in other ways, and is a very different thing from the purposeful application of the method of healing by so-called organization of blood coagula, hardly needs to be mentioned. Nor need I emphasize the fact that loss of blood, as such, is to be guarded against, for it is proven experimentally that general anaemia is a predisposing cause of infection with pyogenic bacteria.

The question suggests itself, what would happen under good antiseptic technique if the so-called dead spaces of a fresh operation wound were left to themselves, that is, were neither drained nor obliterated nor permitted to fill with blood? There is not sufficient experience to answer this question satisfactorily. This, however, is to be considered. Exudations composed of fluid and cells would quickly accumulate in most of these spaces, and these fluids and cells possess anti-bacterial properties as well as blood. Granulation tissue would spring up from the sides. I venture to predict that if the surgeon paid no particular attention to the filling or obliteration of many of the smaller spaces in fresh operation wounds, and if the antiseptic technique were good, the process of healing would be as satisfactory as by any of the other methods mentioned.

Let us now turn our attention to the progress which has been made in the employment of antiseptic agents for surgical purposes. Soon after the introduction of Lister's methods, the search began for new and better disinfectants than carbolic acid. This search brought to light a large number of agents, some good, but more of little or no value for the purpose intended, and in general, carbolic acid continued to possess the field until Koch, by his fundamental experiments with disinfectants, demonstrated the pre-eminent germicidal power of corrosive sublimate. This latter disinfectant has, to a large extent, although not entirely, taken the place formerly occupied by carbolic acid as the surgical disinfectant *par excellence*. In no department of antiseptic surgical technique has the value of bacteriological methods of experimentation been more evident than in establishing the germicidal powers of various real or supposed disinfectants; nevertheless, the importance of not rejecting sound clinical experience in this matter is shown by the fate of iodoform as an antiseptic agent. Iodoform would probably never have been recommended as an antiseptic on the basis of bacteriological experiments alone. Still, the benefits of its employment in wounds and surgical affections are undoubted, and a more careful study of the mode of action and the conditions required for the development of the antiseptic powers of iodoform has justified the use of this substance. A class of disinfectants obtained by fractional distillation at high temperatures of coal-tar oils has recently been introduced, and promises valuable service. These are the higher cresols, which pass over by distillation between 190° and 210°C. The difficulty has been to obtain these oils in a form soluble in water. Creolin is a fine emulsion of these cresols; and lysol, a solution of the same in water by a soap combination. Although, like most new disinfectants, creolin and lysol have not sustained the extravagant claims made for them by their early enthusiastic advocates, nevertheless they possess strongly disinfectant and other valuable properties and are a useful contribution to the list of surgical antiseptic agents.

But surgical disinfection has progressed not so much by the introduction of new chemical disinfectants as by a better understanding of the mode and conditions of their efficient action. It was once supposed that the skin, wounds, instruments, sponges, etc., could be completely disinfected, without any especial precautions, by being placed for a short time in the disinfectant solutions. Misleading inferences were drawn from the powerful germicidal action of chemical disinfectants when brought into contact with bacteria under the most favorable conditions, namely, with bacteria on silk threads or suspended in water. Not sufficient attention was paid to one of the most important results of Koch's investigations of disinfectants—that the presence of oil or fat prevents the parasiticide action of chemical disinfectants. From this it should have been clear that the presence of oily substances in the epidermis, and often, also, on instruments, sponges and other objects used by the surgeon, must frequently render his efforts at disinfection nugatory, unless by the use of alcohol or by thorough mechanical scrubbing with soap and water, he first removes the grease. Hence it might easily happen that those who scouted the use of chemical disinfectants but employed thorough mechanical cleansing of hands, instruments, etc., really attained a higher degree of antiseptis than those who trusted exclusively to chemical disinfection. Thorough mechanical cleansing and scrubbing with soap and water, although it accomplishes much, does not generally bring about complete disinfection and cannot, therefore, alone be trusted, but these measures are essential adjuvants of any method of surgical disinfection with chemical agents. It may be mentioned that the alkaline soaps possess some disinfectant power, often quite as much as especially prepared commercial disinfectant soaps.

The differences in germicidal power of corrosive sublimate under different conditions are much greater than those of carbolic acid and most other disinfectants. Aside from the presence of oily material, the great obstacle against the disinfectant action of corrosive sublimate in the animal tissues and fluids is its precipitation with albuminous substances. So great is the obstacle that it may be doubted whether it is possible to disinfect by means of corrosive sublimate wounds infected with bacteria, and whether irrigation with solutions of corrosive sublimate accomplishes much more in this way than that with sterile salt solution. We owe especially to Geppert the demonstration that former methods of testing the germicidal power of corrosive sublimate were subject to such grave errors that their results cannot be trusted. Geppert has shown that it is necessary to get rid of the sublimate, which can best be done by precipitation with sulphide of ammonium (or other alkaline sulphides), in order to determine whether bacteria subjected to its action have actually been killed or not. When this precaution is taken it is found that corrosive sublimate is a far less energetic disinfectant than has been generally supposed. For example, Koch believed from his experiments that corrosive sublimate in the strength of 1-1000 destroys anthrax spores in one minute, whereas Geppert has shown that the same strength of sublimate may not have killed all of the spores in watery suspension even at the end of 72 hours. In a recent article Geppert has shown that it is really very difficult to determine whether all of the spores are killed or not by sublimate, inasmuch as a definite concentration of the solution of sulphide used for precipitation is required to test this point and the failure to obtain cultures or to infect an animal is no proof that the spores have been killed, for a different concentration of the substance used to precipitate the sublimate or the employment for this purpose of some substance less injurious to the spores might demonstrate still greater resistance against sublimate. Dr. Abbott has gone over the question of disinfection of the staphylococcus pyogenes aureus with corrosive sublimate in my laboratory and his results in conformity with those of Geppert for other bacteria have been made known to you. It may be that the powerful inhibitory and attenuating action of corrosive sublimate upon bacteria is all that is required for the purposes of the surgeon, but it should be understood that this is not equivalent to disinfection, which means the actual destruction of bacteria.

In view of the difficulties and uncertainties of securing under many conditions complete disinfection with chemical agents, especially with corrosive sublimate, it marks a great progress in surgical antiseptics that heat, in the form of dry heat, or live steam, or boiling, is now used so extensively by the surgeon for sterilization of instruments, ligatures, dressings, etc. That chemical disinfectants still have and are likely to continue to have important uses in surgical practice goes without saying.

As I have recently, before the Congress of American Physicians and Surgeons in Washington, presented some of the results of our experience with methods of disinfection of the skin, I shall utilize the present occasion to demonstrate to you a number of culture tubes which illustrate the results of experiments begun by Dr. Halsted, and carried farther by Drs. Ghriskey and Robb, in my laboratory.

A fact important to know in connection with experiments on cutaneous disinfection is that the mercury, probably in combination with albuminous material, remains for many days in the epidermis of hands which have been frequently washed in solutions of corrosive sublimate in the manner customary with surgeons, and this notwithstanding the ordinary daily ablutions with soap and water. Of this I will ask any surgeon present who uses frequently corrosive sublimate for disinfection.

tion of his hands to convince himself by placing his fingers in this solution of ammonium sulphide. A mere brownish discoloration of the surface of the skin after applying ammonium sulphide must not be taken as evidence of the presence of mercury, for this in varying degree can take place with those who have not been in contact with mercurial solutions, but it is the rapid deep brown or black discoloration, especially of the nails, which indicates the formation of sulphide of mercury. A pretty demonstration of the growth of the nails is furnished by the absence of the dark brown color in the part of the nail which has grown since the use of the sublimate solution. Not only may the mercury remain for a long time in the epidermis, but it is capable of preventing the growth of bacteria with which it originally came into contact when scrapings from the epidermis are placed in nutrient agar or gelatine. It does not, however, seem to exert any such inhibitory action upon bacteria which have become attached to the epidermis after the application of the sublimate. That epidermal bacteria which fail to grow in culture media inoculated with scrapings from the surface of the skin after washing with sublimate solutions are not necessarily dead, is proven by their development when the scrapings are taken from the same skin after precipitation of the mercury in the epidermis with sulphide of ammonium. For this result the experiments of Geppert had already prepared us, and it is the failure to precipitate the mercury with an alkaline sulphide which led Fürbringer to apparently better results than we have obtained in testing his method of disinfection of the hands with corrosive sublimate. It is also clear that erroneous conclusions may be derived from testing the germicidal power of any other disinfectant on the skin, if the hands of those who are in the habit of using sublimate solutions on them be selected as the object of disinfection, unless the precaution be taken first to get rid of the sublimate, which is best done by precipitating it as the sulphide of mercury.

If the hands have been washed, say the day before, in a solution of corrosive sublimate, then it may happen that most or all of the bacteria which have become attached to the skin since then can be removed by simple scrubbing with soap and water, or by some solution the disinfectant powers of which it is desired to test, and the cultures made from scrapings of the epidermis prove sterile. That, however, there are still living bacteria in the superficial layers of the epidermis, may be shown by making the cultures after washing the hands in solutions of ammonium sulphide. It is probable, from Geppert's recent work, that we should have obtained even more striking results if we had paid more attention in the experiments to the concentration of the solutions of sulphide of ammonium, but we were not familiar then with the importance of this point, and, as it is, the results were sufficiently striking.

I show you here a series of cultures which are intended to demonstrate the points mentioned. Scrapings from the epidermis or beneath the nails were made with a sterilized knife constructed for the purpose, and were transferred to liquefied agar, which was then rolled or poured into Petri's dishes.

In this first series of agar roll cultures there are three sets of tubes which have been inoculated with scrapings from the epidermis and beneath the nails of one of the assistants in the hospital who is in the habit of making daily use of sublimate solutions. The first set were inoculated with scrapings without any preliminary treatment of the hands; the second after thorough scrubbing with soap and warm water by means of a sterilized brush; and the third after washing the hands, subsequent to the scrubbing with soap and water, with a solution of sulphide of ammonium, which brought out a deep brown or black color of the epi-



dermis and nails. You will observe that all of the tubes of the first set contain a large number of colonies, that two of the tubes of the second set contain no colonies and two contain from three to ten colonies, and that the tubes of the third set contain from twenty to one hundred colonies.

In this second series of agar roll cultures, intended to show the results of Fürbringer's method, the experiment has been made with hands which have not previously been in sublimate solution. The first set of tubes were inoculated with scrapings from beneath the nails without preliminary treatment; the second after thorough scrubbing with soap and water; the third after the use of alcohol, and then washing in sublimate 1-500 for two minutes; and the fourth after washing the hands in sulphide of ammonium, which turned them dark in color. Each step was carried out strictly according to Fürbringer's directions, and double the amount of time which he recommends given to each step. The sublimate was freshly prepared in distilled water. The hands were well washed in sterilized water and then dried with a sterilized cloth before inoculating the third set of tubes. Each set was inoculated with the scrapings from beneath and around the nails and placed in the thermostat at 37°C. You will observe that the first set of tubes are crowded with colonies; that the second contain a smaller number, but still a good many colonies, from twenty to over a hundred; that the third set are sterile, save one colony in one of the tubes; and that the fourth set contain some colonies in each tube, varying from three to twenty-five. Fürbringer inferred from such results as those in the third set of tubes that the sublimate had actually killed all of the bacteria in the superficial layers of the epidermis and beneath the nails, whereas, if he had precipitated the mercury with ammonium sulphide as was done before inoculating the fourth set, he would have learned that this is not the case. It is fair to say that we have sometimes obtained sterile tubes by Fürbringer's method, even after precipitation with ammonium sulphide, and we do not intend to condemn the method as not a good one, but only as not the best, and as not accomplishing all that is claimed for it. As has already been said, it may be that it is sufficient to inhibit the growth of the bacteria in the way that is done by the sublimate, but it is not justifiable to infer that because the bacteria will not grow in our culture media they may not grow in the animal body. It is also to be considered that sublimate is capable of attenuating or destroying the pathogenic power of some bacteria. But even after giving due weight to these considerations, that method which actually kills the bacteria is to be preferred if it is applicable.

The third series of tubes has been inoculated with scrapings from beneath the nails after disinfecting the hands with lysol; and the fourth after disinfection with peroxide of hydrogen, the preliminary scrubbing with soap and water being as in the other experiments. You will observe that neither of these agents has accomplished complete disinfection, there being a few colonies in most of the tubes, the most in the tubes after using peroxide of hydrogen. The hands were disinfected with lysol in the manner recommended by Gerlach.

On the other hand, in this fifth series of tubes inoculated with scrapings from beneath the nails after disinfection with permanganate of potash and oxalic acid in the manner described in my paper before the Congress in Washington, you will observe that all of the tubes are sterile with the exception of one colony in one of the tubes. We, therefore, have adopted in the hospital this method of disinfection of the skin. Whether there may lurk some fallacy in the conclusions which we have drawn from our experiments with this method analogous to that in previous experiments with corrosive sublimate I cannot say, but if so, we have not been able to detect it.

Our experiments with methods of cutaneous disinfection, as well as our observations on the bacteria in wounds treated antiseptically, have led us to a study of the bacteria in the skin. The micro-organisms in the human epidermis have been studied by a number of investigators, as Bizzozero, Bordoni-Uffreduzzi, Unna, Maggiora, Mitmann and Preindlsberger, and a large number, over a hundred different species, have been more or less perfectly described. Our purpose has been not to make a complete study of the bacterial flora of the skin, although we do not regard such a study in the light of Fürbringer's characterization of it as a "zeitraubende, geistestödtende, wenig fördernde Beschäftigung," but rather to learn something about the frequency of occurrence of the most common pyogenic cocci, about the most common bacterial inhabitants of the epidermis and about the possibility of the presence of bacteria in layers of the epidermis not reached by existing methods of cutaneous disinfection.

In conformity with Fürbringer's statements as to the relation between the occupation of an individual and the bacteria present beneath the nails, we have found the staphylococcus pyogenes aureus only very exceptionally in the epidermis or in the subungual dirt of those who have had nothing to do with suppurating wounds, abscesses or other surgical cases, but on the other hand have found this organism repeatedly on the skin or beneath the nails of surgeons or their assistants. The bearing of these observations are sufficiently apparent to need no further emphasis.

We have found a white staphylococcus far more frequently than any other organism in the epidermis and beneath the nails after the superficial bacteria have been removed by scrubbing the hands with soap and water or by incomplete disinfection, as by washing with sublimate. Unna and others who have studied by culture methods and have paid attention to the relative frequency of the different kinds of bacteria on the skin have also noted the frequency of occurrence of a white coccus liquefying gelatine. Unna regards this most common coccus as the staphylococcus pyogenes albus. We have observed that this common epidermal staphylococcus liquefies gelatine and coagulates milk more slowly than the typical staphylococcus pyogenes albus, and that a centimeter and more of bouillon cultures can be injected without effect into the veins of rabbits. Whether this coccus is a distinct species or only a modified form of the staphylococcus pyogenes albus, we have not been able definitely to decide, but I have proposed for it, provisionally, the name staphylococcus epidermidis albus. Other white cocci also occur in the skin. We have met, several times, forms corresponding to the micrococcus cereus albus (Passet), the micrococcus candicans (Flügge) and the micrococcus albus liquefaciens (v. Besser). Von Besser has found in the normal air passages a white staphylococcus resembling the staphylococcus pyogenes albus save by the absence of pathogenic properties. In general, the classification of the white liquefying micrococci is difficult and unsatisfactory. There are differences in the rapidity of liquefaction of gelatine by our staphylococcus epidermidis albus and occasionally we have isolated forms which correspond in mode of growth to the staphylococcus pyogenes albus, but have not isolated any with the pathogenic powers of this coccus, so far as we have been able to test this point. We have also occasionally found in the epidermis a staphylococcus resembling closely, in the appearance of its colonies on agar and its scarcely visible growth on potato, the typhoid bacillus.

We regard as the most important outcome of our studies of the bacteria of the skin the demonstration of the presence of the staphylococcus epidermidis albus, less frequently of other bacteria, in layers of the skin deeper than can be reached by existing methods of disinfection of the skin. The significance of this fact is apparent when I tell you that this same coccus is the one which we have found

in a very large number of laparotomy wounds treated by the most careful antiseptic or aseptic methods and that it is the most frequent cause of stitch abscesses. We have found it so often in the deeper layers of the epidermis that we are inclined to consider it a regular inhabitant of the skin. It has only feeble pathogenic power ordinarily, but it is capable of causing suppuration. The injurious influence of a drainage tube in checking the repair of fresh healthy wounds is illustrated by the fact that it is chiefly in wounds containing drainage tubes that we have observed suppuration to result from the presence of this organism, and that often the suppuration is limited to the track occupied by the tube. This coccus is found not only in stitches around which suppuration has occurred, but also in those without any visible inflammatory reaction around them.

I show you here a number of cultures of this organism. These three cultures were made in the following way: the skin of a patient before an operation was thoroughly disinfected by the method already described, so that scrapings from the surface afforded no growth, then by means of a sterilized instrument; sterilized silk threads (tested by cultures), were drawn from one to five or six times through the disinfected skin and these silk threads were then dropped into liquefied agar, the tubes were agitated and then rolled on ice. You will observe that several white colonies (varying from two to ten), and coalescent colonies have developed, especially along the sides of the thread. The remaining five agar roll cultures have been inoculated with silk sutures removed from the skin, four to seven days after antiseptic laparotomies, pursuing in each case a perfectly aseptic course and without any evidence of inflammatory reaction around the stitches. Each of these tubes contains colonies of the white staphylococcus, varying from six to fifty in number.

We have found also other bacteria, and twice the staphylococcus pyogenes aureus, in skin stitches withdrawn after antiseptic operations, but the staphylococcus epidermidis albus is by far the most common. To judge from the number of colonies developed from sterilized threads drawn through the skin after complete disinfection of the surface it would seem as if the white staphylococcus were not particularly abundant in the epidermis. Further investigations, which must be microscopical, are necessary to determine the exact part of the epidermis or hair follicles or glandular appendages of the skin occupied by these bacteria, and here the methods recently described by Unna are likely to be of service.

I hardly need to say that these observations on the bacteria of the normal skin, and the depth to which they penetrate, indicate that the skin of the patient may be a source of wound infection and that the surgeon should take greater precautions than has hitherto been customary, to guard against this danger. Dr. Halsted, in view of our results on cutaneous disinfection, has discarded for the most part the use of cutaneous sutures, and is very well satisfied with the results obtained by bringing the edges of wounds together by subcutaneous sutures.

I have endeavored, gentlemen, to bring before you, although in a disconnected way, a few of the improvements in antiseptic surgery since Lister's pioneer work, as they present themselves to one looking at the subject from a bacteriological point of view. Surely progress has been great, but there is no reason to suppose that the ideal has yet been reached and that there is not room for further advance. Even in directions where it now seems to us that the goal is attained we must be guarded in our predictions, lest we make ourselves as ridiculous to future generations as to us seems the leading surgeon of his day, Boyer, when in the early part of this century he wrote "Surgery in our day has made the greatest progress and appears to have attained, or nearly so, the highest perfection of which it is capable."

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BALTIMORE, NOVEMBER 14, 1891.

**Editorial.**

**SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL  
FACULTY OF MARYLAND.**

We publish elsewhere in the present issue of the **JOURNAL** a programme of the semi-annual meeting of the State Faculty, to be held in Rockville on November 17th and 18th.

It will be observed that a number of addresses and papers have been provided for the meeting, and that the work promises to be of an instructive and profitable character. Rockville, the county seat of Montgomery, is centrally and conveniently located, and in every respect a most advantageous point for the meeting. It is within easy reach by rail and is amply provided with hotel accommodations for the entertainment of all who attend. The selection of this place was urged by the Montgomery County Medical Society, a young but active local organization. The committee of arrangements has felt that in the selection of Rockville as a place of meeting at this time an opportunity would be offered to a large number of physicians in Central and Southern Maryland to take part in the work of the Faculty. It is hoped that this will be the case, and to further this end a cordial invitation is extended to the profession throughout the State to take part in this meeting. The meetings held in Hagerstown and in Cambridge have been of very great value to the profession in Maryland. It is believed that the Rockville meeting will be likewise productive of much pleasure and benefit to all who attend, apart from its far-reaching value to the profession throughout the State.

We can not urge the importance of this meeting with too much earnestness. It should be another step in the direction of more thorough medical organization in Maryland. There are a number of matters of professional interest incidental to this meeting which should be carefully considered. The Legislature, which meets in Annapolis after January 1st, will be called upon to enact a law to regu-

late the practice of medicine in this State. This subject should at this time receive the most careful attention and a movement should be inaugurated at Rockville looking to the preparation of a suitable bill to be presented to the Legislature. Unless the profession moves intelligently and promptly in this matter, the experience of previous years may be repeated.

An occasion such as is proposed should draw a large number of physicians together for mutual acquaintance and co-operative work. The opportunity should not be disregarded, for men even with the burden of responsible medical work should not forsake the assembling of themselves together upon such occasions. We hope to see a large attendance, and we promise a most agreeable meeting to all who come.

#### UNIVERSITY EXTENSION.

The University Extension movement is a missionary development in the educational sphere, which has for its object the education in various branches of useful science of those who have not the time, or lack the means to obtain regular college or university instruction. The promoters of the movement attempt to gain their benevolent ends by arranging for courses of lectures, by eminent scientific instructors from the various educational institutions within reach, to which any person with a thirst for knowledge may gain admission, either *gratis* or upon the payment of a reasonable fee. The lectures are given in the evening or at such a time as busy people may find convenient.

According to Mr. Henderson (*Popular Science Monthly*, November, 1891), the movement has in this country assumed three phases.

1st, The *Local* plan, originated in Baltimore by Professor Adams, of Johns Hopkins University, and in Buffalo by Dr. Bemis.

2nd, The *State* plan which is peculiar to New York.

3rd, The *National* plan, proposed by Dr. Pepper, of the University of Pennsylvania.

The movement is of interest to physicians, not only because of the attraction which benevolent enterprises have always exerted upon them, but because the patient who has some appreciation of what science is, and what it is doing for him, is the patient who honors most his medical adviser, and shrinks most from the enticements of uneducated quacks.

It is pleasant to see that one of the greatest departments of the University Extension work has been instituted by a well known member of the medical profession.

#### THE ROLLER BANDAGE FOR PAINS OF SPINE DISEASE.

The experience of the late civil war taught our older practitioners that patients wounded in the chest could be moved with far greater comfort if the body were snugly bound with a roller bandage from the arm-pits to the crest of the ilium.

In the *Medical News*, August 29, 1891, Dr. Leidy states that, having found that the spasmodic and painful conditions of the limbs which so often follow severe injuries could be greatly relieved by the firm application of a roller bandage, he was led to use this principle in the relief of the pains of locomotor ataxia. The "girdle" pains vanished almost immediately upon the application of a bandage, similar to the obstetrical band, firmly about the body at the level of the pain; and this, even after absolute rest, galvanism and the other therapeutic measures commonly employed had failed. In one instance the girdle pains returned several hours after the bandage was removed.

The firm application of a flannel bandage from the toes to the upper third of the thigh gave great relief from the pains in the limb. Two patients invariably suffered from a return of the pains in the lower limb whenever the bandage was taken off.

In several instances where the pain was definitely localized, benefit resulted.

Dr. Leidy had now used this method for six months in his practice. He thought the relief was due to the warmth, pressure and rest. In some cases elastic stockings may be employed. The method should certainly be tried in cases where the patient is in danger of the morphia habit. It is to be hoped that our readers will test its merits in their own practice.

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#### LEGITIMATE PHARMACY.

It is pleasant to learn that the effort made recently by a certain firm of druggists to conduct a business strictly limited to the filling of prescriptions and the sale of apparatus needed by the physician and the nurse, and to the supply of tablets for physician's use to physicians, has been very successful. The advertisement of its business by the firm under the title of Legitimate Pharmacy was keenly resented by other druggists, who maintained that they too were doing a "legitimate" business, and, further, that there were a number of prominent firms in the city who had endeavored to limit their business to pure pharmacy, but had been compelled, in order to meet the public demand, to extend it somewhat beyond those limits, though not far beyond them. The firm whose success is now announced deserves credit for proving that a pharmacy *can* be advantageously conducted now in Baltimore without counter-prescribing; the furnishing of 15 cent bottles of whiskey to thirsty car-drivers, and the dispensing of soda water either simple or fortified by various alcoholic preparations; the supply of all sorts of patent medicine, either on demand of the public, or on the *prescription of physicians*; or the handling of a large stock of promiscuous articles to meet the toilet needs of families.

The writer does not hold that there is anything "illegitimate" or improper in such methods of doing business, and is glad to express his appreciation of the courtesy and assistance which he has always received from druggists. But, while the "neighborhood" druggist will be compelled for a long time to come to supply

many little necessities to his customers and to give them now and then his advice as to the best remedy for stomach ache or "tetter," it is to be hoped that other moneyed firms in starting into business in our city will endeavor to confine their business to those matters which more properly belong to pharmacy. The greater attractiveness and order of the store, the freedom from little distracting demands upon their attention, and the leisure for attending to their own chosen profession, will compensate them for the loss of outside business, and probably a good pecuniary return will be obtained.

### Medical Progress.

#### THERAPEUTIC EFFECT OF DIURETIN.

Dr. Geisler (*Berliner Klinische Wochenschrift*, 1891, Nos. 15, 17), comes to the following conclusions:

1. Diuretin increases the the blood pressure.
2. It should be regarded not only as a diuretic, but also as a cardiac remedy.
3. Its most striking effects are observed in disturbances of circulation brought about by valvular insufficiency.
4. In affections of the heart muscles its diuretic effect is much weaker.
5. In acute nephritis its diuretic action is much stronger than in chronic nephritis.
6. In cirrhosis of the liver no diuretic action is observed.
7. In the healthy individual the quantity of urine is somewhat increased.—*Jour. Cut. and Genito-Urin. Dis.*

#### PHLEGMASIA DOLENS.

In the *Canada Lancet*, November, 1891, Dr. M'William, in an article reviewing his experience with this disease, gives the following summary:

First—That we have in salicylate of soda a remedy that does modify the disease to a very great extent. I think I may fairly claim that it obviates almost entirely the tendency of the disease to become chronic.

Second—That to obtain this result, the drug has to be pushed to get its full physiological action, and persevered in for at least six or eight days.

Third—That the reason the drug does not seem to act with such promptitude as it does in rheumatism is:

(a) That the subjects of phlegmasia dolens were very anæmic and weak, and consequently bad subjects for the exhibition of such a drug as soda salicylate.

(b) That in phlegmasia dolens we have an inflamed condition of veins to overcome as well as a morbid condition of the blood.

Fourth—That the treatment of phlegmasia dolens by soda salicylate rests on as reasonable grounds as that of acute rheumatism. As, if we grant that rheumatism is due to the blood sepsis, arising from the presence of a special germ in the organism, and that soda salicylate is a potent remedy, and more or less effectual antidote for that condition, it is not unreasonable to suppose that it would be quite as effectual in the treatment of phlegmasia dolens. For without claiming any necessary relations between the two diseases, they seem to have some points in common, as for example, the condition of anæmia, and the excess of fibrin in the blood that exists in the majority of cases, the proneness of each to

become chronic, and, lastly, should the result of my experience be borne out by further clinical observations, we will have another striking similarity, in that both diseases are beneficially affected by the action of the same drug, soda salicylate.

As Dr. M'William indicates, salicylate of soda, if tried in this diseased condition, should be used with great caution. Phlegmasia dolens is a process involving generally a phlebitis of the veins of the lower limb, and in addition to this some peculiar condition of the lymphatic fluids and tissues of the limb. It is believed to be, as a rule, a septic disorder, associated often with septic changes in the parturient canal or peri-uterine tissues. As it occurs in greatly debilitated patients, and usually terminates in recovery under very simple treatment, the use of large and continued doses of such a powerfully disturbing agent as salicylate of soda should not be advised unless it gives the most positively beneficial results.

#### CANNABIS INDICA.

If the statements of Dr. Mattison, of Brooklyn, in the *New Orleans Medical Journal*, November, 1891, are reliable (and judging from his extensive hospital experience they ought to be so), this valuable drug is not used as much as it deserves to be used. The following extracts are drawn from Dr. Mattison's article:—

Indian hemp is not a poison. This statement is made, just here, because the writer thinks a fear of its toxic power is one reason why this drug is not more largely used. This mistaken idea lessens its value, because it is not pushed to the point of securing a full therapeutic effect. This is a fact. One of the best pharmacologists in this country not long since expressed a very touching solicitude lest the writer's advocating robust doses of this valued drug might cause a decrease in the census that would seriously imperil his professional good repute.

There is not on record any well-attested case of death from cannabis indica. Potter says: "Death has never been produced." Hare asserts: "No case of death from its use in man is on record." Bartholow affirms. "Cases of acute poisoning have never been reported." Stillé states: "We are not acquainted with any instance of death." Wood declares: "Hemp is not a dangerous drug; even the largest doses do not compromise life. No acute fatal poisoning has been reported." A prolonged personal experience, compassing the history of many cases—men and women—and hundreds of doses, ranging from 30 to 60 minims of the fluid extract, has never brought any anxiety along toxic lines.

My experience with hemp covers more than a decade, many cases, and several pounds of fluid extract. It is proper to state that these cases have been solely habitués or ex-habitués of opium, chloral or cocaine. In these, often, it has proved an efficient substitute for the poppy. Its power in this regard has sometimes surprised me. Both sexes took it, and with some no other drug anodyne was used. One of these—a naval surgeon, nine years a 10 grains daily subcutaneous morphia taker—recovered with less than a dozen doses. My oldest female patient—64—found its service complete. Its action has varied, as some cases respond more fully. This during the early abstinence time. Later, it has done good in the post-poppy neuralgia, especially the cranial kind, and it has calmed mental pain and unrest.

Failure with hemp is largely due to inferior preparations, and this has had much to do with its limited use. It should never be called inert till full trial with an active product produces it.



Another cause of failure is too timid giving. I am convinced that the dose of books is often too small. The only true way is, once a good extract, push it to good effect. My doses have been large—40 to 60 minims of the fluid extract—over-large for the narcotic habitué; but, as we years ago asserted, habitual poppy taking begets a peculiar tolerance of other nervines, and they must be more robustly given. Both sexes have taken them—women frequently—with no other effect than quiet and sleep. I think, for many, small doses are stimulant and exciting; large ones, sedative and quieting. They are the outcome of an experience with smaller doses that failed of effect desired. They prove hemp harmless, and they add proof to the opinion of most neurologists that, once a nervine needed, it is often better to give one full dose than several small.

The tincture—3 grains to the drachm—may be given in doses of 20 to 60 minims. The fluid extract 5 to 20 minims. The solid extract  $\frac{1}{2}$  to 2 grains. Tannate of cannabin, 5 to 15 grains. Cannabinone,  $\frac{1}{2}$  to  $1\frac{1}{2}$  grains. Cannabinone with milk sugar, 5 to 15 grains, and each repeated or increased till a full effect is secured. It is said that in women cannabinone acts twice as strongly as in men. In headache, periodical or long continued,  $\frac{1}{2}$  to 2 grains solid extract may be given each hour or two till the attack is arrested, and then continued in a similar dose, morning and night, for weeks and months. It is important not to quit the drug during a respite from pain.

I close this paper by again asking attention to the need of giving hemp in migraine. Were its use limited to this alone, its worth, direct and indirect, would be greater than most imagine. Bear in mind the bane of American women is headache. Recollect that hemp eases pain without disturbing stomach and secretions so often as opium, and that competent men think it not only calmative, but curative. Above all, remember the close genetic relation of migraine relieved by opium to a disease that spares neither sex, state nor condition.

Dr. Suckling wrote me: "The young men rarely prescribe it." To them I specially commend it. With a wish for speedy effect, it is so easy to use that modern mischief-maker, hypodermic morphia, that they are prone to forget remote results of incautious opiate giving.

Would that the wisdom which has come to their professional fathers through, it may be, a hapless experience, might serve them to steer clear of narcotic shoals on which many a patient has gone awreck.

Indian hemp is not here lauded as a specific. It will, at times, fail. So do other drugs.

#### SOME OF THE NEWER HYPNOTICS.

The following items are culled from an article by Dr. Zenner in the *College and Clinical Record*:

*Paraldehyde* is a less powerful hypnotic than chloral, but does not subject the patient to the danger of habit, nor does it threaten the heart. Its taste, occasional disturbance of the stomach and irritating effects on the bronchial tubes, in cases of bronchitis, are its chief objections. Its usual dose is one drachm, but it may safely be given in four times that quantity.

*Amylene hydrate* is said to be about equal to paraldehyde as a sleeping medicine, and to have none of the objectionable qualities of the latter, just mentioned. It is given in all forms of insomnia, the dose varying from ten to one hundred grains.

*Urethan* is a mild and agreeable, but less certain, hypnotic, and is not used very extensively.

*Sulphonal* has, perhaps, become the most popular of the recent hypnotics. The average dose necessary to promote sleep is from twenty to thirty grains. It is slower in producing its effect than other hypnotics, usually a few hours intervening before drowsiness is felt. This is because the medicine is very slowly absorbed from the stomach. This can be remedied to some extent by having the medicine finely pulverized and administered in a large quantity of hot fluid, bouillon, milk or the like. It will generally fail to promote sleep when the latter is prevented by pain. On the other hand, it is of special value when there is great motor restlessness, in chorea, maniacal conditions and the like. In large doses, when long continued, it is likely to cause a sense of vertigo.

A still newer remedy, and likely to receive equal favor with sulphonal, is *chloralamid*. This is a combination of chloral and formamid, but is said not to have the ill effect of the former, especially not to affect the heart or disturb digestion. Like sulphonal, it usually acts slowly, one to one hour and a half usually passing before sleep is produced. But it seems to have a somewhat more favorable influence than sulphonal in promoting sleep when pain is a disturbing element. The dose varies from fifteen to sixty grains. It is soluble in one and one-half parts of alcohol, or twenty parts of cold water. It should not be given in hot solutions, as it is decomposed by heat.

*Hydrobromate of hyoscine* is of special value in motor restlessness and the like. It is most frequently used in cases of insanity, especially maniacal conditions. Ordinarily the dose mentioned is from  $\frac{1}{150}$  to  $\frac{1}{100}$  of a grain, but it is given in maniacal cases in much larger doses, even as much as one-tenth of a grain hypodermically.

#### PHARYNGITIS.

For a case of pharyngitis complicated with bronchitis, Dr. Brinton gave the following:

℞.—Ammonii chloridi . . . . .	gr. v.
Vini antimonii . . . . .	gtt. x.
Vini ipecacuanhæ . . . . .	gtt. x.
Mist. glycyrrhizæ comp. . . . .	f ʒj.

M. Sig., every three or four hours.

—*Times and Register.*

#### EUROPHEN.

As it is well that the practitioner should know something of the new remedies, even before their value has been thoroughly tested, we give the following account of this new antiseptic which is designed to replace iodoform.

It is obtained by the action of iodine upon isobutylortho cresol. Its pharmacology and bacteriology have been studied by Siebel, and its therapeutic action by Eichhoff.

Europphen is an amorphous, yellow powder, exhaling a slight odor resembling that of saffron. It is insoluble in water and in glycerine, and is more soluble than iodoform in alcohol, ether, chloroform and the oils. Europphen adheres better than iodoform to the skin and to open wounds, and an equal quantity of it by weight will cover a surface five times greater.

This iodide of isobutylortho cresol is not toxic. Dogs were found to take two or three grammes of it with impunity, and the human organism will bear one gramme of it without unpleasant phenomena save a slight feeling of weight in the stomach.

The urine of patients who had absorbed europphen did not contain iodine.

Eichhoff employed it successfully in dressing both hard or soft chancres. He

used it as a powder, and also in the form of one per cent. or two per cent. ointment. He furthermore employed it successfully in hypodermic injections in patients suffering from the secondary and tertiary symptoms of syphilis. These injections consist of one gramme of europhen to 100 grammes of olive oil, and of this, one-half to one cubic centimetre was injected daily in one dose.

Eichhoff also employed europhen in varicose ulcer and ulcerative lupus as well as in eczema, psoriasis and favus, in all of which it proved to be efficacious.

Ointments containing one per cent. to two per cent. of europhen are as strong as need be used. Five per cent. ointments caused a certain amount of irritation.

#### INFLAMMATION OF THE PROSTATE.

The following is recommended by a French writer as very efficacious in the relief of chronic prostitis:

R.—Iodoform . . . . .	gr. xx.
Olive-oil . . . . .	3 ij.
Cocoa butter . . . . .	q. s.

Divide into twenty suppositories, one to be inserted at bedtime.

#### Obituary.

##### DR. THOMAS B. EVANS AND DR. T. BARTON BRUNE.

It is our sad duty to add two more names to the list of physicians of Baltimore who have recently deceased. Within six weeks we have lost four prominent and much-loved members of our profession.

Dr. Christopher Johnston and Dr. Edmund R. Walker had been long forewarned by unmistakable symptoms that the summons might come at any moment; those whose death we are now called upon to notice were cut down by acute disease in the full vigor of active life.

DR. THOMAS B. EVANS, a prominent practitioner of East Baltimore, died Friday, October 30th, at his residence, 121 Jackson Place, in the 59th year of his age. He occupied the chair of Pathology and Clinical Medicine in the Baltimore University School of Medicine, and at the time of his death was Dean of the Faculty. He was a graduate of the Medical Department of the Washington University, of this city, and, in addition to the practical duties of his profession, made a number of valuable contributions to the journalistic literature of medicine. His cheerful disposition and hearty manner made him ever welcome in the social circle. The eloquence and grace of his public addresses were the pride and delight of his friends. He was a member of the Maryland Academy of Sciences, the Medical and Chirurgical Faculty of Maryland, and an honored member and ex-president of other local medical societies.

DR. T. BARTON BRUNE, a physician and obstetrician of North Baltimore, died Monday, November 9th, in the 36th year of his age, at his residence, 1815 N. Charles St. He was a graduate of the University of Maryland School of Medicine (class of 1878), and Resident Physician at the Infirmary, 1879-80. His grave manner and accurate knowledge of medicine gained for him early in his professional career a clientage among wealthy and cultured citizens seldom reached by the young practitioner.

In urinary analysis, both qualitative and quantitative, he was unusually skillful, and his translation of Hoffman and Ultzmann's work upon this subject, as

well as his numerous contributions to medical journals, made him widely known throughout this country.

Dr. Brune was one of those who endeavored, some years ago, to establish a Post-Graduate School of Clinical Instruction (Polyclinic), in this city. He was a very active worker in the Medical and Chirurgical Faculty of Maryland, and was, at the time of his death, chairman of its library committee. He was greatly beloved, and highly respected for his faithful and efficient work, by a large circle of patients and acquaintances.

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### Medical Items.

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Owing to the uncertain results of the tuberculin treatment in the military hospitals of Russia the authorities have issued instructions that in the meantime, at any rate, it must be discontinued.

The French Association for the Advancement of the Sciences will hold its next meeting at Besançon, in 1893. Professor Bouchard has been elected Vice-President for the ensuing year.

The English consul at Canton says that eighty thousand pounds of human hair have been exported from that city during the past year, and that it comes mainly from those who have died of contagious diseases, mendicants and criminals.

The *Pharmaceutical Journal of Australasia* informs us that the "university extension" idea, to which we referred in a recent number of this JOURNAL, has struck Australia. In Ballarat, over fifty persons have entered their names for a course of lectures which is to be given in the Alfred Hall each Monday evening.

The deaths of the following distinguished members of the medical profession abroad have been announced: Dr. Fischel, Emeritus Professor of Mental Diseases in Prague, in his seventy-ninth year. Dr. Adolf Schauenstein, Professor of State Medicine in Graz, and author of works on Medical Jurisprudence and Hygiene.

The Medical and Chirurgical Faculty of Maryland will hold its semi-annual meeting at Rockville, Md., on November 17th and 18th, at which the following papers will be read: Address by the President, Dr. Wm. H. Welch, on "The Bacillus Coli Communis, the Conditions of its Invasion in the Human Body and its Pathogenic Properties;" The Rest Cure and Cases to which it is Applicable, by Dr. G. J. Preston; Typhoid Fever, by Dr. Edward Anderson; Cases of Addison's Disease, by Dr. Wm. Osler; Notes on the Use of Codeine, by Dr. A. K. Bond; Hereditary Syphilis, by Dr. R. B. Morison; A Case of Elephantiasis of the Scrotum, by Dr. R. Winslow; A Case Illustrating the Diagnosis of Extra-Uterine Pregnancy and the Difficulty of Producing Abortion, by Dr. J. E. Michael; Early Diagnosis and Operation in Osteo-Sarcoma of the Lower Bones, by Dr. Chas. E. Stone; Appendicitis in the Female, with Report of Two Cases, by Dr. T. A. Ashby; Report of Fifty Consecutive Operations for Cataract, by Dr. R. L. Randolph; Treatment of Internal Hæmorrhoids by Galvano-Cautery, by Dr. S. T. Earle; Laparotomy for Removal of a Purulent Tumor of the Right Ovary, by Dr. Robert T. Wilson; Occupation and Disease, with Special Reference to the Connection between the Inhalation of Dust and Pulmonary Disease, by Dr. Wm. B. Canfield.

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NO. 556

## CONTENTS

### ORIGINAL ARTICLES.

The Simple Extraction of Cataract. By Edward Jackson, M. D., of Philadelphia. . . . . 67

Cephalic Version After the Beginning of Labor. By Wm. S. Gardner, M. D., of Baltimore. . . . . 71

### EDITORIAL.

The United States Medical Practitioners' Protective Alliance. A Warning. . . . . 75

Medical Education and the Student's Wants. . . . . 76

Cephalic Version. . . . . 77

### MEDICAL PROGRESS.

Toxic Effect of Tobacco Vapor.—The Care of the Milk Teeth and of the Permanent Teeth.—Notes on Breast Milk.—Exalgine in Diseases of Children.—"Attenuation" of Micro-Organisms.—Continued Fevers of the South.—Corn Plasters.—A Plea for the More Liberal Use of Butter.—Traumatic Lesions of the Spine.—Edema of the Lungs.—As Simple as Sneezing.—Treatment of Infantile Paralysis.—Condylomata.—Gonorrhœa in the Female.—The Dog.—Medical Practice in Japan.—Local Anæsthesia for Slight Operations.—Septic Disease of the Umbilicus.—Treatment of Hiccough.—Asphyxia. 78

MEDICAL ITEMS. . . . . 87

## Original Articles.

### THE SIMPLE EXTRACTION OF CATARACT.†

BY EDWARD JACKSON, M. D.,

Professor of Diseases of the Eye in the Philadelphia Polyclinic, and Surgeon to Wills Eye Hospital.

The old flap operation for the extraction of cataract, when it was successful, was one of the brilliant triumphs of operative surgery. The trouble with it in the old time, before the day of Graefe, was, that it was successful in only a minority of cases. The real achievement of the last few years with reference to it has been the increasing of the percentage and the perfection of its success, until they have surpassed anything achieved by other operations for cataract extraction. This has been brought about by collateral advances in medicine and surgery, that have given us an understanding of sepsis and asepsis, of the myotic power of eserine and its allies, and of the anæsthetic and other powers of cocaine.

My purpose in this paper is to discuss the operation of "simple extraction" as I practise it, with the reasons for choosing certain procedures rather than others, and some comparison of the results of the method with modified linear extraction, or modified Graefe method, which it has largely replaced.

*The corneal section* is made upwards, mainly because it seems to me that the wound in this position is much better protected beneath the closed lids from either infection or the relative displacement of its lips than the downward section can be. It is made in the clear cornea, sometimes as close as it can be to the limbus without encroaching on it. It is parallel to the corneal margin, the plane

†Read before the Philadelphia County Medical Society, October 28th, 1891.

of the knife making it being parallel to the plane of the periphery of the iris. It is made to include nearly, and sometimes quite, half of the circumference of the circle of which it is a part. The exact position of the section and its length are determined by the size of the cornea and the supposed size of the lens. The plane of the section should be well in front of the iris, for the risk of prolapse of the iris is thereby greatly lessened, yet the incision must be long enough to permit the escape of the lens. The section is made with the knife described by me in the *American Journal of Medical Sciences* for March, 1888, for the reason there given, that it combines to a large extent the manageableness of the Graefe knife with the smooth incision of the Beers knife. Usually the incision is almost completed by the forward thrust, the cutting edge being carried by it out of the anterior chamber, and the remaining bridge of corneal tissue severed as the knife is withdrawn.

*The capsulotomy* is made with the point of the knife used in making the corneal section, and is about in the plane of the corneal section, as the lens lies against the cornea after the escape of the aqueous. I have in a few cases opened the capsule before completing the corneal section, as the point of the knife was carried across from the puncture to the counter-puncture. This was done in the fear that after the escape of the aqueous the pupil would contract so that it would be difficult or impossible to make a sufficient laceration of the capsule without wounding the iris with the knife point. Such a manœuvre, however, required a slight change in the direction of movement, and prolonged a little one of the most critical periods of the operation. It was given up on finding that a sufficient opening in the capsule can always be made through the pupil after the completion of the corneal section. The opening that it is necessary to make in the capsule is really quite small; a slit 4 or 5 mm. long is quite sufficient, probably because when the solution in the continuity of the capsule is once started it extends quite readily, as widely as it is needed, under the pressure of the lens during the stage of its delivery.

The advantages of this method of opening the capsule are that by it we get rid of one instrument, the cystotome—an instrument hard to keep clean at the shoulder from which the pricking point projects, hard to get and keep perfectly sharp, liable from its shape to catch and damage the cornea or iris in case of sudden movement while it is in the eye, and which I have seen more than once, by its direct backward pressure, dislocate the lens and allow the escape of vitreous. Then the small opening in the capsule, nearly in the direction of the corneal section, seems to have a decided influence in making sure of the proper rotation and presentation of the lens in the corneal wound; and cortical matter as well as nucleus has a perfectly direct avenue of escape; and if cortical matter remains after the nucleus has been extracted, it remains inside the capsule, and not in the anterior chamber where it would exert its well-known deleterious influence on the iris; or, as some have supposed, furnish an especially favorable culture medium for the pathogenic bacteria introduced on the shank of the cystotome or along a path of capsule incarcerated in the corneal wound. Again, with this method of opening it, there is no chance that portions of the capsule will prolapse or become incarcerated in the wound, and so complicate the healing and endanger the ultimate result more insidiously, but quite as seriously, as prolapse or incarceration of the iris.

This method of opening the capsule has this disadvantage, that when the pupil contracts, as it does in the process of washing out the anterior chamber, the iris sometimes entirely covers up the rent in the capsule and makes it much more difficult to dislodge any remaining cortical matter. Under these circumstances, it

is best to make no effort to dislodge it, for, in my experience, cortical matter *left within the capsule* after the removal of the lens nucleus is innocuous, and is certain to be removed by absorption in a few weeks at the furthest, causing some delay in the full restoration of vision and detracting from the brilliancy of the operation, but in the end giving the patient the best result.

*The delivery of the lens* is effected by making pressure with a lens spoon backward on the lower portion of the cornea, and with a corneal spatula slightly downward upon the upper ciliary region, causing the lens to push into the pupil and engage in the corneal wound, the movement of the lens being steadily followed by a slight upward movement of the spoon, and the necessary pressure never relaxed until the the greatest thickness of the lens has passed through the corneal section. It is of the utmost importance that the pressure be maintained steadily; any intermitting of it that causes the lens to alternately advance and retreat is liable to bring about the displacement of the lens, and the presentation of the vitreous in its stead. After the nucleus has escaped, the pressure is gently continued until any evident masses of cortex have also been extruded, and then withdrawn.

*Washing out of the anterior chamber* I have practised after the method and with the apparatus of Dr. Lippincott, of Pittsburg, for the last year, as the principal step in the operative toilet. If the iris has prolapsed, the stream of boric acid solution is the simplest and best repositor, its effect being to carry the iris into position, and at the same time to provoke a marked and very satisfactory contraction of the pupil. If the opening in the capsule remains freely accessible, the current may be directed into it and all lenticular *debris* removed. But if this is not readily accomplished, I content myself with a thorough washing out of the anterior chamber, at the end of which the pupil is found small and central, stroking of the iris with the spatula, or poking into the angles of the corneal wound to dislodge incarcerated iris or capsule being thus dispensed with.

*Eserine is instilled* after the washing of the conjunctival sac, although usually the effect of the irrigation of the anterior chamber has been to already secure a small central pupil, in order that the contraction of the pupil may be maintained and the iris drawn as far as possible away from the cornea. In a single case in which I omitted the use of eserine a slight prolapse of the iris appeared at the end of thirty-six hours. Eserine was then used, and the prolapse promptly reduced. Later, however, it again appeared, and the pupil was left somewhat distorted.

*Simplicity.* As compared with the Graefe method and its modifications, "simple extraction" deserves its name, in that the iridectomy that it dispenses with is the most painful and one of the most delicate portions of the former operation, and that the uninjured iris is more readily reduced and kept wholly within the eye than the iris that has lost the tensile action of its sphincter. It prevents the extremely insidious accident of incarceration of the capsule. Again, the dangers of that, serious complication, prolapse of the vitreous, are reduced to a minimum. Without rough handling, or especially unfortunate movement of the eyeball, it is scarcely possible for this accident to occur before the nucleus is delivered. Even in a case of dislocated lens with fluid vitreous the delivery of the lens was readily effected without the use of a spoon or loop, and no vitreous was seen until this had been accomplished.

*Ease.* The statement is usually made that with simple extraction the delivery of the lens is slightly more difficult. But, in my experience, this is true only to a slight extent as to the complete removal of the cortical matter. The delivery of the nucleus is not to any notable extent more difficult. I operated yesterday on a

case where the lens was particularly large and the cornea small. From the other eye, in which the conditions were precisely similar, I had removed the lens several months ago, after a preliminary iridectomy, with a good deal of difficulty. The simple extraction was, if anything, the easier one. After the first operation a considerable amount of cortex remained in the capsule, and the same thing occurred with the second. Still, the removal of all remaining cortex is, I believe, a little more difficult after the simple extraction, though certainly not more dangerous.

*Prolapse of the iris.* The danger of this complication is the greatest drawback on simple extraction—about all that keeps it from being an ideal operation. When any considerable prolapse occurs it causes a distorted pupil, is liable to delay the healing, is followed by unusually high astigmatism, and if very large might endanger the eye. The impression is abroad that it is very much more likely to happen after simple extraction than after extraction with iridectomy; at least, it is scarcely counted as one of the risks of the latter operation. But iridectomy does not prevent the occurrence, except of the part of iris that has been removed. Indeed, in so far as it removes the restraining influence of the iris sphincter and leaves angles of iris floating within the eye, iridectomy directly favors incarceration, the form that prolapse assumes after it. Knapp has recently reported statistics of about five hundred cases of simple extraction, with prolapse of the iris in eight per cent. of the cases. It is probable that incarceration of a part of the iris at the angles of the wound is about that common among Graefe's extractions. In my own work prolapse has not been more common after simple extraction than was incarceration after iridectomy. More than this, the great mass of cases of prolapse under the use of eserine flatten down and cause as little trouble as the incarcerations after iridectomy, and do this without excision or any other special treatment, without notably delaying the healing, and, so far as can be judged, without any additional ultimate danger to the eye. I speak thus particularly about prolapse of the iris, for it was fear of it that kept me for a considerable time from giving up iridectomy. Still, prolapse of the iris is the chief danger of the method and it should be carefully guarded against by the use of the eserine, by keeping the patient as quiet as possible, by avoiding any pressure of the dressing or through the dressing on the globe, and by placing the corneal section as far away from the iris as possible, compatible with making it large enough to permit the escape of the lens.

*Visual acuteness.* The principal advantage of the simple operation is the exclusion from the eye of a large amount of very imperfectly focussed light, and the retention of the power of adapting the eye promptly and fully to the varying intensity of the light to which it is exposed. This advantage, although shown partly by statistics of visual acuteness, can never be fully exhibited in that way. An eye may be able to decipher even the smaller test-types, although their image on the retina is engulfed in a flood of unfocussed light coming in through distorted portions of the cornea opposite the coloboma left by an iridectomy. But even with only the ability to make out the same type, the vision secured by the exclusion of this useless and confusing excess of light is for all practical purposes far superior.

Again, we find in age the retina habitually guarded against even the light admitted to the younger normal eye by a diminished pupil; and the reversal of this, the flooding of the senile eye, with its slower nutritive processes, with an amount of light largely in excess of what it has been accustomed to, especially the crippling of its power to defend itself against sudden increase of illumination, cannot



but diminish its powers of resistance to unfavorable influences, and lead to ultimate deterioration of vision.

It was watching the gradual deterioration that occurred in certain eyes that had been subjected to extraction, with iridectomy, that first made me desirous of trying the simple method.

*Indications for iridectomy.* I am not aware of any operator who proposes the abandonment of iridectomy in all cases. It is pretty certain that in at least one class of cases all will continue to practise it, namely, those in which from iritic adhesions or from other causes the pupil is extremely rigid and undilatable. The other indications for it are not so well agreed upon, but probably one of the most important of them is extreme restlessness and insubordination on the part of the patient. All of my cases of prolapse have been in patients markedly of that character. For the present most of us will be apt to fall back on iridectomy for a number of reasons, as I did in a case about a week ago, where there was reason to suspect a large lens and saccharine diabetes, so that I feared sloughing from a large corneal flap. But with myself, as with many others, the present tendency is to do iridectomy less and less frequently, and it is probable that the cases in which it is either necessary or desirable will ultimately be found to be few and far between.

### CEPHALIC VERSION AFTER THE BEGINNING OF LABOR.

BY WILLIAM S. GARDNER, M. D.,

Lecturer on Obstetrics in the College of Physicians and Surgeons; Attending Obstetrician to the Maternity Hospital, Baltimore.

Cephalic version, mentioned by Hippocrates, practiced for centuries by the Arabians, finally fell into disuse, and was only revived in Europe about the beginning of the present century. At the present time it is spoken of as the exceptional operation, for which exceptionally favorable conditions must be present. Ordinarily it is stated that cephalic version may be performed when the child is in a transverse position, if the waters have not escaped and the uterine contractions are not too strong. The difficulties of the operation have been exaggerated, and its advantages, especially those to the child, have been belittled.

*Indications.*—When the pelvis is sufficiently large to allow the passage of a living child, cephalic version is indicated in all presentations where neither pole is presented to the superior strait, and in many, if not all, breech presentations. The limits of the possibility of performing it are very slightly less than that of podalic version. The practicability and even the possibility of doing either cephalic or podalic version in cases where the waters have long escaped, and the uterus firmly retracted upon a large child, wedged firmly in the pelvis, is always a matter for grave consideration. But the single fact that the waters have escaped does not necessarily contra-indicate cephalic version. Two cases have been recently reported, in one of which the waters had escaped three hours before the operation, and, in the other, fifteen hours had elapsed before turning was attempted. In one of my own cases the waters had escaped several hours before I saw the patient. Yet, in not one of the cases was any special difficulty encountered. Cephalic version is not recommended in placenta prævia because the legs of the child can be made to plug up more effectually the partially dilated cervix. In cases where repeated breech presentations in the same patient have resulted in the death of the infants, cephalic version before labor is positively indicated.

The advantages of cephalic version over podalic version operate in favor of both mother and child. To the mother the shock of the operation is not so great, especially when the version is done, as it usually is, by external manipulation. The increased danger of laceration of the cervix in podalic version is avoided. This danger is greater after podalic version than in ordinary breech presentations, for the reason that the head is often dragged rapidly through an only partially dilated os. In cephalic version the danger of laceration of the perineum by the rapid extraction of the after-coming head is avoided.

The foetal mortality due to podalic version is difficult to estimate, because the operation is usually done under or on account of such circumstances as would in themselves endanger the life of the child, if its delivery be attempted by any method through the natural channels; consequently it is plainly unfair to charge to an operation results that may be entirely independent of it. But it is certainly giving the operation liberal treatment to say that as a result of the position obtained by the operation, the foetal mortality is at least as great as in breech presentations.

The foetal mortality in breech presentations is so variously estimated from hospital reports that we can estimate only approximately what the mortality is in general practice. Dubois estimated that one child in eleven, or about nine per cent., of children presenting by the breech are still-born. This is, presumably, under the very best management. No reference is made to the frequency of lacerations of the cervix or the perineum, which were undoubtedly very common. Churchill estimates the foetal mortality at one in  $3\frac{1}{2}$ , or 30 per cent. Galabin says that at Guy's Hospital, where the cases are attended by students, that the foetal mortality in breech presentations is one in 2.7, or 37 per cent.; and in foot or knee presentations one in 2.2, or 45 per cent. The estimate of Dubois shows the percentage of mortality under the most skillful management; that of Guy's Hospital under the management of students, presumably the least skillful; and Churchill's estimate is, in all probability, very close to the results obtained by the average good practitioner.

Bearing in mind the statement of Tyler Smith that, "Spontaneous pelvic presentations are less dangerous, both to the mother and child, than artificial pelvic presentations procured by the operation of version," and also the fact that the foetal mortality in vertex presentations is not more than two or three per cent., the above estimates are certainly arguments in favor of cephalic version that can not be successfully disputed. It must not be understood that I would abandon or decry the valuable operation of podalic version; but it undoubtedly should be limited to that relatively small number of cases to which cephalic version is not applicable.

Before attempting cephalic version, it is of course necessary to make out accurately the position of the child. In some instances this can be done by vaginal examination, but much more frequently it must be done by palpation. Even in primipara it is not often that the abdominal walls are so tense as to interfere with the external examination. The patient should be flat on her back with the knees flexed. Standing at the side of the patient, with his face toward her feet, the examiner places his warm hands at first gently on the abdominal wall, and then pressing the fingers of each hand deeply into the corresponding iliac region, he presses the finger tips of each hand toward the other. In this way the lowest segment of the uterus and its contents are grasped between the two hands. If the head is down it can be recognized easily by its shape, resistance, and by what is of very great importance, the crease corresponding to the neck.

If the head is not found in this segment of the uterus, we then know that the child is in one of the more unusual positions. Grasping between the fingers in the same way successively the lateral halves and the fundus of the uterus, it is usually quite easy to make out not only the position of the head and back of the child, but very often the limbs can be found.

Auscultation, though much inferior to palpation, is of some service in locating the position of the child.

Generally speaking, in head presentations, the foetal heart is heard with the greatest distinction below a line which crosses the uterus transversely at a point half way between the symphysis and the fundus of the uterus. This line usually runs about one inch below the umbilicus. The objection to taking the umbilicus as a guide is that it is not a fixed point and its relation to the uterus varies greatly in different women. In pelvic presentations the heart sounds are heard usually above this line. In no presentation is the relation of the foetal heart sound to a given point on the abdominal wall definite.

When a malpresentation has been made out there are four methods that have been used to correct it. One of the older methods is by posture. This consists simply in making the patient lie on that side to which it is wished that the breech should gravitate, and waiting. While this method has succeeded, it is too uncertain to be of very great practical value. The principal details of the other methods will be given in the relation of the cases. Before beginning the operation by any method, it is necessary that the rectum and bladder be emptied.

CASE I.—C., colored, multipara, was brought to bed with twins. The first child presented by the vertex and was born without assistance. The second child presented by the left shoulder, the head being in the right iliac region. The second bag of waters was unruptured. An attempt was made to rectify the position by external manipulation without an anæsthetic, but on account of the uterine contractions it failed. Chloroform was then given with the intention of doing a podalic version; but upon introducing my hand I found the child so movable that I grasped the head, brought it to a L. O. A. position and retained it there until the pains returned. The labor was then allowed to proceed without interference, and in a few minutes a living child was born.

The objections to this method of turning are that it is rarely available, and necessitates the introduction of the whole hand into the uterus, which is one of the greatest objections to podalic version as it is usually performed. What was gained was the avoidance of the dangers of the after-coming head. In this particular case very little danger was to be apprehended from the after-coming head, but what there was was forestalled by having the head come first.

CASE II. A. B., white, primipara. Labor began about 1 P. M., September 7, 1890, at which time she informed the nurse that her "sickness had come on." By digital examination the attending physician found clots in the vagina and a partially dilated os, through which no part of the child could be felt. That evening the hæmorrhage was controlled by tamponing the vagina with cotton. The case came under my charge September 8. Upon removing the tampon, the cervix was found to be only slightly dilated and filled with blood clots. No part of the child could be reached through the vagina. By external examination the head was found in the right iliac region and breech opposite. At 12.30 P. M., under chloroform, by external manipulation the breech was pushed upward and the head forced down until it occupied the lower segment of the uterus and was ready to engage in the superior strait. The tampon was not replaced and there was no further hæmorrhage. The pains were not strong and the os dilated

slowly. At 10.47 P. M., the os having dilated about one half, and the pains being very weak, the membranes were ruptured. After this the pains became stronger. During the night chloroform to the obstetrical degree was given. At 6 A. M., the os was fully dilated, but the head, in the R. O. P. position, did not descend. At this time, under chloroform, forceps were applied, and at 6.35 the head, unrotated, was delivered. The perineum was not torn. Both mother and child did well.

CASE III.—No. 1780, colored, aged 16, primipara. Labor began about noon, April 7, 1891. I saw her for the first time the following day about 1 P. M. Upon digital examination I found that the waters had escaped, the cervix partially dilated, the head of the child in the right iliac region, and the right arm of the child in the vagina. As I withdrew the examining finger the child's hand came through the vulva.

Chloroform was at once given, the arm put back into the uterus, the shoulder pushed up from the superior strait by the fingers of the right hand, while the head was fixed with the left hand. As soon as the arm was safely in the uterus the right hand was applied to the breech, and by pushing it up, at the same time the left hand pushed the head down, the presentation was quickly converted into a vertex. The chloroform was stopped and the living child was born, without further interference, in less than an hour.

Undoubtedly the best method of doing cephalic version is by external manipulation. Mundé puts it in this way: "The paramount advantage of version by external manipulation is the avoidance of the always more or less hazardous passage of the whole hand into the uterus." The operation is not difficult, and any one who is at all familiar with palpation ought to have no difficulty in performing it.

Next to the external manipulation in ease and safety of performance is the combined method, while the method of passing the hand into the uterus and grasping the head is less valuable both on account of the infrequency of the conditions favoring its performance and on account of the shock to the mother.

Whether a cephalic version shall be done should not be looked upon as a question of the convenience of the physician, but as a question involving the safety of the mother and the life of the child. By these facts and cases I have endeavored to show that in cephalic version we have a neglected operation which presents no special difficulties in performance, and which if carefully cultivated will undoubtedly reduce our foetal mortality.

712 N. Howard St.

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Membership in the American Pharmaceutical Association is obtained only by election at the annual meeting. Every pharmacist and druggist of good moral and professional standing, whether in business on his own account, retired from business, or employed by another, and those teachers of pharmacy, chemistry and botany who may be especially interested in pharmacy and materia medica are eligible for membership. For blank application and further information, address Dr. H. M. Whelpley, 2729 Washington Avenue, St. Louis, Mo., chairman of the Committee on Membership.

A prize of three thousand francs (\$600) has been offered for the best essay on the subject of "Latent Tuberculosis," to be presented to the next Congress of Tuberculosis, which will probably meet in 1893.

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**THE MARYLAND MEDICAL JOURNAL.**

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A. K. BOND, M. D., Editor.

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BALTIMORE, NOVEMBER 21, 1891.

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### Editorial.

#### THE UNITED STATES MEDICAL PRACTITIONERS' PROTECTIVE ALLIANCE. A WARNING!

We read with astonishment in the editorial columns of the *Medical News*, November 7, 1891, a lengthy endorsement of this association, with a recommendation to physicians to hasten to join it.

The editor of the *News* must surely have accepted the statements of the officers of the association without further examination of the subject.

The association has not made itself known to the leaders of the medical profession in Baltimore, but the ethical standing of certain of the association's promoters is well known.

According to the published statement of the Medical and Chirurgical Faculty of Maryland (in its transactions for 1890, page 119), the "founder" of the "United States Medical Practitioners' Protective Alliance" was expelled in April, 1890, from the State medical society of Maryland, for violation of its code of ethics (identical with the code of the American Medical Association); the offence, which is not there stated, being that he advertised himself in the daily papers, giving as an endorsement his membership in the Faculty, and refused to discontinue advertisement.

The "President" of this "Alliance" is now (according to a hand-bill distributed through the city, of which a copy is now before us), Medical Director of the "National Bureau of Medical, Surgical, and Hygienic Relief of Baltimore City," the successor and heir of the "Bureau of Medical Relief" whose principles and practices as stated in the editorial columns of the JOURNAL, September 12, 1891, are utterly condemned by all physicians of standing in Baltimore with whom we have conversed on the subject.

Announcements of an enterprise which seems to have been identical with this

“Alliance” (as the “founder” bore the same name), were made from time to time, unofficially, in the *Medical Record* some months ago, but after a private note of warning had been received by the editor of that excellent journal, the announcements ceased.

The present announcement appears officially in the *News*, and we therefore deem this public warning concerning it necessary, as the simple endorsement of an enterprise by the *News* would naturally secure the confidence of the profession. We judge that this “Alliance,” like the enterprise noted in the *Record*, collects from its members a membership fee (\$3); we cannot see what return it can possibly make for the investment.

#### MEDICAL EDUCATION AND THE STUDENT'S WANTS.

An extract in the *Canada Lancet* from the *British Medical Journal* contains so much common sense that it deserves still further quotation.

“So important a step as entry into a medical school is apt to make the student, his friends, and even the public forget that his studies are a means, not an end. He must ultimately earn his bread by physic, provided that he satisfies examiners. It may pertinently be asked: Does the education at medical schools fit a man for earning his bread? and do examiners necessarily pass the fit while rejecting the unfit?”

That our medical schools do honestly endeavor to give the students a good, solid, scientific ground-work of knowledge there can be little doubt. Unfortunately the teachers must, above all, pass as many of their men as possible. Hence medical education is too closely associated with passing examinations. In short, the end is partly sacrificed to the means.

Another shortcoming in the modern system lies in the fact that the student will most probably become a general practitioner, whilst his teachers are purely scientific professors or members of the hospital staff. Their knowledge of general practice is at the best indirect. The hospital teacher in many cases is a product of the school where he teaches. Professionally speaking, he may have never stirred from his hospital. He has had a hard struggle, but not of the kind which most of his pupils must undergo. He has been a demonstrator or a registrar, has read papers at societies, and has had to send testimonials to governors—documents which usually inform them that he is “peculiarly fitted” for the appointment which he has afterwards gained, and that he is a “gentleman.” Then he has discharged the duties of physician or surgeon and teacher, first in the out-patient department and lastly in the wards. We all know what patience and self-denial are demanded of men who work their way up to leading positions in great medical centres. But they are not in a position to teach the student precisely what is required of the general practitioner. The young qualified man will have to start at once with his patients—provided that they come to him. His teacher has often not so much as thought about patients till he has nearly attained his 30th year. His substantial gains are more often derived from pupils.

The young practitioner must learn human nature, and must not prescribe by rule-of-thumb nasty ready-made mixtures. He may at any moment be called to undertake a serious responsibility far from consultants, assistants, good nurses, and sanitary "homes" for patients. Thus he has to learn much that he has not been taught in his school, and this at his own or his patient's cost.

Lastly, the merited success of many men possessing only the so-called "lower" qualifications suggest that hard examinations sometimes crush common sense, and even discourage perseverance, whilst favoring youths of scientific or literary ability. It is clear that something is wanting in medical education. A move in the right direction has been made by the General Medical Council, which has recommended that the fifth year of medical study be spent in hospitals or dispensaries."

Heretofore the instruction in the medical colleges of the United States has been given almost entirely by professors who have been at the same time engaged in general practice. The want of high scientific attainments on the part of these teachers has been to some extent counterbalanced by their knowledge of the practical needs of the young graduate. With the raising of the standard of scientific attainment in the schools of this country, it is to be hoped that private practitioners will never be altogether banished from the teaching staffs.

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#### CEPHALIC VERSION.

We take pleasure in presenting to our readers in the present issue an article by Dr. Garder upon this subject. The views there set forth demand careful consideration by every practitioner who wishes to do the very best for his parturient patients and their offspring.

We deem it our duty, however, to caution those who are wholly unskilled in the manipulations of obstetrics against attempting thus to change breech presentations into presentations of the vertex. We have recently heard of a case in which a couple of such unskilled practitioners attempted to change a breech to a vertex presentation in this way, but got the child fixed firmly half way, with a presentation of the side, and had to call a skilled operator to help them out of their difficulty. There are many physicians in the community who will confess to their intimate medical friends that they do not know anything about obstetrics; and there are many others confident of their own ability, concerning whom their friends will make the same confession.

In the hands of skillful operators, even though they lack the experience of Dr. Gardner, cephalic version ought to be possible in most cases. It should not be done before labor has really begun, else the vertex may move away from the cervix into its old position. In difficult cases a medical assistant should be called who can keep the uterus thoroughly relaxed with chloroform during the operation.

### Medical Progress.

#### TOXIC EFFECT OF TOBACCO VAPOR.

An article upon this subject by Dr. Chapman in the *Medical Progress* contains many observations of interest. The writer avoids the more obscure manifestations of tobacco poisoning and dwells chiefly upon the graver and more dangerous conditions due to its inhalation and to its absorption. The article was suggested by observation of symptoms exhibited by certain children, who were occupied, at the tobacco stemmeries, in carrying the steamed tobacco from the steaming tanks to the men who do the stemming. The children when first they begin this work are seized with violent vomiting and purging, perhaps with collapse. After this initiation has been safely passed the children become in most cases inured to the occupation and do their work without disturbance of health.

In some instances, however, the child loses his health, although no acute sickness occurs after the initial one. Emaciation sets in; and from time to time paroxysms of abdominal pain, with slight fever, redness of tongue, obstinate constipation, coldness of hands and feet, dryness of skin and deficient secretion of urine are experienced.

In the mildest cases of this chronic poisoning of tobacco workers, free dosing with castor oil and change to some form of labor not connected with tobacco manufacture, suffices for a cure. In more severe cases protracted illness and even death results.

Dr. Chapman discusses carefully the cause of the toxic disease in question, and gives full notes of several cases. The disorder seems to be due to *nicotianine*, which is present in tobacco along with nicotine, and which produces symptoms like those observed in these little tobacco-carriers.

The subject of poisoning by tobacco-vapor demands further investigation.

#### THE CARE OF THE MILK TEETH AND OF THE PERMANENT TEETH.

In a short article upon this subject in the *Texas Sanitarian*, a dentist, prompted by the fact that many physicians failed to appreciate the importance of care of the teeth of the young and its bearing upon the general health, makes the following suggestions:

After the eruption of the temporary teeth, the most important particular is their preservation. They should be preserved (if possible), until they are replaced by the permanent set. If the temporary set are preserved, in due time absorption of their roots takes place, the little crowns become loose and fall out or can be easily extracted. Premature removal of temporary teeth often causes irregularity of the permanent teeth in this way: It is not that their removal shortens the maxillary bone, but when they do not occupy their respective place, the bone does not grow as it should, consequently when the permanent teeth are ready to be erupted, there is not sufficient room between the teeth for proper development, and they are forced out of their regular positions.

It is a well known fact that the structure of the deciduous teeth is more delicate than that of the permanent set, and they are almost invariably subject to decay, and the deposit of a calcareous salt, commonly called "tartar." This salt, or tartar, is a precipitate from the saliva; it is often found firmly attached to the teeth near the gum margins. There are several varieties of tartar, but we will only speak of the kind most destructive to the deciduous teeth; this is called "green stain," and is very deleterious to teeth structure. When once allowed to



deposit on the teeth, it gradually encroaches beneath the gums, causing irritation, inflammation and finally suppuration; periosteal trouble ensues, and other serious complications are liable to follow. In addition to this the green stain, as seen on the deciduous teeth, has the effect of chemical abrasion, which softens their structure, causing the teeth to waste away. When it is found to exist, it should be carefully cleansed off, and a suitable wash prescribed to prevent its recurring.

Lastly we will call attention to the first permanent tooth which is erupted when the child is in her fifth or sixth year, and is called the "sixth year molar." This is the largest of all the teeth of the permanent set, and gives prominence to the cheeks. This tooth is often mistaken for a temporary tooth, and as such allowed to decay; in fact, we are often called on by the parents of the little sufferers to extract this tooth, and when we protest, they say: "Why, is not that tooth soon to be shed?" Indeed, they seem to be greatly surprised when told that it is a permanent tooth, and very important to preserve the regular features of the face. When it is found that the teeth are decaying, they should receive the earliest possible attention. When a child finds that by the act of mastication, particles of food are forced in through the decayed crown of these teeth upon the sensitive nerve, he will no longer chew his food properly. He will bolt his food whole and get dyspepsia.

Acidity of the saliva is the common cause of caries of children's teeth. This may be detected by test paper and should be corrected by proper treatment.

#### NOTES ON BREAST MILK.

After a thorough study of the subject, Dr. Ivanoff, in a medical thesis published at St. Petersburg, in 1890, states that:

1. The cellules of colostrum are of epithelial origin.
2. In multiparæ colostrum changes to milk more rapidly than in primiparæ.
3. Puerperal diseases retard the disappearance of the colostrum corpuscles.
4. These corpuscles reappear in the milk after ten months of lactation, and when the infant is only partly fed from the breast.
5. The free hyaline corpuscles, as well as those which are enclosed in the fatty globules, form a constituent of normal milk at a certain period of secretion.
6. Good health, good nutrition, and youth in a mother give a milk richest in fatty globules of large size, as is also true of the cellules.
7. The last portion of milk taken at a feeding holds fewer globules, and these of smaller size, than the first portions.
8. The estimation of the nutritive quality of milk should be based upon the number of fatty globules; and secondarily, upon their size, the quantity of cellular element, and, finally, upon the quantity of granules.
9. Milk which contains a very large number of fatty globules (more than 3½ per cent.) is not well borne by very young infants.
10. Milk, the globules of which are large, is less nutritive and less well borne.
11. The maximum of daily increase of weight of the child is produced by milk which contains a mean quantity of fatty globules of medium size (27.7 grams daily).
12. The milk which contains few fatty globules gives little increase of weight (16 grams daily); and the same is true if the fatty globules are in too great quantity or are too large (19 grams daily).
13. Women, who are thin and young in general are the poorest nurses, often

making the children dyspeptic and giving them a mean daily increase of weight of only 11.5 grams.

#### EXALGINE IN DISEASES OF CHILDREN.

When a drug has proven of value in the diseases of adults, it is always of interest to observe its effects upon children and the doses required for their treatment. Dr. Moncorvo's observations on the use of exalgine in the department of pediatrics are, therefore, of value.

His researches (*Bull. Gén. de Thérap.*, quoted in *Journ. Nerv. and Ment. Dis.*, November, 1891), have been carried out on a total of twenty-one children from the age of one and a half years to twelve. In all these cases the exalgine was given to combat the element of pain, and exceeded his expectations. In fact, in not a single case was he disappointed in its effects, and in every instance tolerance was perfect. There was no dizziness, ringing of the ears, or other unpleasant effect observed. Ordinarily the action of the drug was easily obtained, amelioration of the pain being generally established in an hour after the administration of the drug, not rarely it was quite abolished by that time.

The following are the conclusions reached by Dr. Moncorvo:

The great activity of exalgine as an analgesic has been, without exception, well demonstrated in these twenty-one diverse cases of pain.

2. In children complete tolerance has been established, and in no case was there any appearance of disagreeable results.

3. The initial dose should be five cgm. ( $\frac{3}{4}$  gr.) a day and rise progressively to 30 cgm. ( $4\frac{1}{2}$  grs.) a day.

4. The drug may be given in any acceptable way—solution, capsule, or placed on the base of the tongue and washed down by a swallow of wine and water.

5. Exalgine surpasses antipyrin in activity, even in cases where the dose of the latter is five times as great.

6. The value of the drug as a nervine seems probable from the results obtained in one case of chorea.

#### "ATTENUATION" OF MICRO-ORGANISMS.

In an address on "Contagion and Immunity" in the *Texas Sanitarian*, November, 1891, Dr. McLaughlin makes the following statement:

Ferment organisms and pathogenic bacteria can be "attenuated" by certain methods; that is, their ability to do their specific work may be diminished, or totally destroyed; and this change, "attenuation," in the organism may be so firmly fixed that it will be transmitted through heredity from generation to generation of its organism, without in the least changing its natural appearance, even under the microscope, or its power of growth and reproduction. This is a remarkable fact, and I question if it has its parallel in organic development, unless it is found in other simple cells and low organisms. The yeast cells may be attenuated,—modified in their molecular structure, to such an extent that they will grow and multiply in brewer's wort, without causing fermentation, or producing a particle of alcohol. This has been accomplished by Oscar Breffeld, and as a matter of fact, is carried on as an industry in the preparation German "barm." Other ferment organisms can be attenuated, modified in their specific power, in a similar manner. Pathogenic bacteria, those which cause infectious diseases, can also be "attenuated" or weakened in their power of producing certain products—ptomaines. Now, as these ptomaines are poisons, and are proved to be causes of the symptoms and pathological lesions of infectious

diseases, it can readily be understood that their virulence would be lessened by their attenuation, and that the disease or epidemic which they cause would be mild or severe in proportion to the virulency of its cause.

Hence ferment organisms and pathogenic bacteria can be modified alike by environmental causes.

#### CONTINUED FEVERS OF THE SOUTH.

In an elaborate article upon the continued fevers of the south (*Nashville Journal of Medicine and Surgery*, November, 1891), Dr. Humphreys, of Texas, sums up his views as follows.

1. The fevers of southern latitudes are, as a rule, similar in their symptoms, etiology and pathology, differing only in degree, which is probably due to difference of environment.

2. Intermittent fevers are seen less frequently than formerly. Remittent fever is now the prevailing type, and is often ushered in under the guise of an intermittent.

3. True intermittent and remittent fevers are controlled now, as formerly, by the judicious use of quinine.

4. Continued malarial fevers cannot be arrested by any known specific treatment. Quinine, given as herein suggested, has had a salutary effect this season upon the course of our continued fevers.

5. Typical cases of typhoid, or true enteric fever, are rarely if ever seen here; but atypical forms are met with occasionally in the rural districts, and more frequently in the towns and cities.

6. Malarial remittents have manifested a continued character when neglected or inefficiently treated at the outset, but have subsequently yielded to quinine.

7. Antipyrin has not apparently produced any changes in the different types of fever. The intermittent and remittent types, when otherwise promptly treated, have been speedily and easily arrested, although the patients received antipyrin freely.

8. The continued fevers, under the occasional use of antipyrin, have uniformly declined between the eighteenth and twenty-first days—their continuity thereby in nowise being apparently increased.

#### CORN PLASTERS.

As a rule the family doctor knows little about the cure of corns (scientifically known as *clavus*). Yet the treatment of the affection is very simple, and yields large profit to those persons who are not ashamed of the humble title of corn doctor.

Dr. Whelpley gives the following suggestions as to treatment: Among the corn plasters made without the use of salicylic acid is one composed of forty parts of resin cerate, forty parts of galbanum plaster, fifteen parts of verdigris, five parts of turpentine (the oleoresin), and three parts of creosote.

There is also in the market a corn plaster which is ordinary adhesive plaster with about fifteen per cent. of salicylic and a small percentage of benzoin.

Salicylic acid is sometimes associated with arsenic in the proportion of two drachms of the salicylic acid with one drachm of arsenious acid and one ounce of vaseline. This is used as a salve on linen.

Another corn plaster is made of salicylic acid one part, Burgundy pitch and yellow wax one part.

A caustic corn salve is made by mixing a hot saturated solution of caustic soda or potassa with twice its bulk of glycerite of starch.

A solution for the cure of corns has been made by dissolving thirty grains of tannic acid in one ounce of a mixture of equal parts of tincture of iodine, acetic acid and glycerine.

#### A PLEA FOR THE MORE LIBERAL USE OF BUTTER.

Hutchinson, of England (*Columbus Med. Jour.*), makes the following earnest plea for the free use of butter:—No dietetic reform would, I believe, be more conducive to improved health amongst children, and especially to the prevention of tuberculosis, than an increase in the consumption of butter. Our children are trained to take butter with great restraint, and are told that it is greedy and extravagant to eat much of it. It is regarded as a luxury, and as giving a relish to bread, rather than as in itself a most important article of food. Even in private families of the wealthier classes these rules prevail at table, and at schools and public boarding establishments they receive strong reinforcements from economical motives. Minute allowances of butter are served out to those who would gladly consume five times the quantity. Where the house-income makes this a matter of necessity, there is little more to be said than that it is often a costly economy. Enfeebled health may easily entail a far heavier expense than a more liberal breakfast table would have done. Cod liver oil costs more than butter, and it is besides often not resorted to till too late. Instead of restricting a child's consumption of butter, I would encourage it. Let the limit be the power of digestion and the tendency to biliousness. Most children may be allowed to follow their own inclinations, and will not take more than is good for them. The butter should be of the best and taken cold. Bread, dry toast, biscuits, potatoes and rice are good vehicles. Children well supplied with butter feel the cold less than others, and resist the influenza better. They do not "catch cold" so easily. In speaking of children I by no means intend to exclude other ages, especially young adults. Grown-up persons, however, take other animal fats more freely than most children do, and are besides allowed much freer selections as to both quality and quantity. It is not so necessary to raise any clamor for reform on their account. It may be out of place to remark that if a greatly increased demand for fresh butter should result from a change of custom such as that suggested, it could easily be met by those concerned. There need be no increase in the cost of the article, whilst at the same time a benefit would be conferred on our home farmers.

#### TRAUMATIC LESIONS OF THE SPINE.

Finding that little or no notice at all is given to this important subject in text-books, or even in encyclopædias of surgery, Dr. Manley, of New York City, discusses the matter carefully in the *Journal of the American Medical Association*, November 14, 1891, briefly summing up his conclusions.

He considers it proven:—

1. That in the vast majority of cases in which complete paraplegia immediately sets in, after spinal injury, it may be assumed, with almost positive certainty, that the medulla-spinalis has sustained a palpable lesion of its integrity, which usually ends mortally.

2. That there is no proof that mere concussive force will either simultaneously or consecutively ever lead to paralysis, without inducing well-marked and positive pathological changes in the anatomical elements of the cord.

3. Physical force and the psychological effects of fright being the same in railroad as other injuries, there is nothing to justify the claim that there are

grave lesions of the spine resulting from railroad collisions which are characteristic and peculiar.

4. There being no proof of the existence of such diseases as anæmia or hyperæmia of the cord, as pathological entities, they are entitled to no place in the nomenclature of traumatic spinal diseases.

5. Eccentric lesions of the back, without any implication of the cord, may, nevertheless, by pressure on the meninges secondarily give rise to meningitis, local or general; also by infection, propagated inward, ultimately effect the medulla-spinalis. Those extrinsic injuries may, too, of themselves, by inducing pathological changes in the bones, cartilages, joints or muscles, occasion a permanent weakening or loss of power in the back.

6. It should be constantly borne in mind that there are always essentially two different and distinct sets of pathological lesions which result from spinal injury, viz., those involving the cord, of rare occurrence and generally fatal, and those exterior to the spinal cord, very common, but seldom giving rise to serious impediment of function.

#### CEDEMA OF THE LUNGS.

Dr. M'Kee writes to *Columbus Med. Jour.* that Grossman has recently made some remarkable experiments concerning œdema of the lungs in Vienna. He has found that an acute pulmonary œdema occurs in dogs, and not, as hitherto supposed, in rabbits alone, from obstruction of the left auricle and compression of the left ventricle. He has learned that transudation plays but a secondary role in the causation of dyspnœa, and that the most important obstruction to respiration is the inflexibility of the lung on account of the œdema. On account of the vascular engorgements there occurs an enlargement of the alveolar spaces, that is, an enlargement of the lungs. He considers transudation a factor of no importance in dyspnœa. We not only have a congestion and œdema through muscarin intoxication, but also swelling and stiffness of the lungs and bronchial cramps. He thinks that his investigations prove the primary cause of congestion of the lungs to be the narrowing of the left side of the heart, contrary to the theory of Conberm-Welch, who considers it due to paralysis of the left side of the heart. Moyer, contrary to his previous belief, has found pilocarpine to have a most happy effect on the treatment of pulmonary œdema.

(The practical physician must, however, be reminded that in certain states of great bodily weakness, pilocarpine must not be used, or must be used with great caution, for the relief of such œdema.)

#### AS SIMPLE AS SNEEZING.

The successful treatment of that alarming and dangerous condition, spasm of the glottis, is oftentimes difficult and uncertain, but Sir Morell Mackenzie tells us that by setting up a rival reflex, the laryngeal spasm, itself a reflex usually due to peripheral irritation, may be overcome instantaneously. All one has to do is to get the sufferer to take a pinch of snuff or pepper, or failing either condiment, to excite sneezing by tickling the mucous membrane of the nares. The immediate result is a paroxysm of sneezing, after which the patient sinks quietly back to sleep, breathing like a new-born infant. The treatment is logical as well as practical, and is well worth a trial.—*Med. Brief.*

#### TREATMENT OF INFANTILE PARALYSIS.

As stated in the *Journal of Nervous and Mental Diseases*, Dr. Simon, the renowned Paris specialist in children's diseases, recommends the following treatment for infantile paralysis: At first counter-irritation along the vertebral

column at the points corresponding to the roots of the paralyzed nerves. At the same time stimulate the functions of the skin by warm baths or vapor baths, given to the child in bed.

Chloral, aconite and conium are used to calm the nervous excitement.

After the first week electricity should form the basis of the treatment. Weak galvanic currents should be used, the negative pole being placed in a basin of water, into which the hand is plunged, while the positive pole is applied labile to the arm and shoulder. Length of treatment, eight to ten minutes.

Later, faradism is to be used, but always with the greatest prudence.

#### CONDYLOMATA.

The treatment of condylomata may be summed up as follows:

1. Many disappear when kept dry by the application of powders, the best being either calomel or boracic acid.
2. In some cases an astringent, such as tannic acid, will effect a cure; but many cases require more radical measures.
3. In the more severe cases, all treatment should have as its object the destruction of the base of the growth. In ordinary cases, electrolysis is the best treatment. In very severe cases the galvano-cautery is the very best treatment, as there is no hæmorrhage, and little pain. The Pacquelin cautery and escharotics almost invariably leave a painful wound, confining patient to bed.
4. After removing condylomata, the condition that caused them should be treated, otherwise they are apt to redevelop.

#### GONORRHŒA IN THE FEMALE.

Bumm (*Centralbl. f. Gynäk.*), from a long study of this subject, concludes that gonorrhœa in women is a process limited to the superficial layer of the mucosa; the cocci invade the epithelial layer, but are always arrested when they reach the submucosa. The epithelium is originally cast off by reason of the active suppuration, but is quickly renewed, assuming the pavement form; after this change has occurred the active invasion of gonococci is usually arrested, but they continue to grow in the secretion, in which they may persist for months and years. The gonococci have no connection with septic processes; they do indeed cause suppuration of the mucosa, but are destroyed when they reach the subjacent connective tissue. If sepsis develops it must be in consequence of mixed infection; septic germs are frequently present in gonorrhœal pus, and a favorable nidus for the reception of external germs is offered by the purulent genital secretion. The urethra and cervical canal are the favorite seats of gonorrhœal infection; acute gonorrhœa of the cervix gives rise to symptoms only at the outset, but after it has become chronic it may exist for years without causing disturbance, unless it extends to the corpus uteri and thence to the tubes.

The cocci possess no power of spontaneous movement and extend only short distances by proliferation. Extension over larger surfaces must be through the agency of the secretion. Normally the cervical secretion cannot pass the os internum, which also serves as a barrier to the entrance of the specific infection. Menstruation favors the admission of cocci into the uterine cavity, also certain mechanical causes, such as coitus, the introduction of sounds and intra-uterine medication; lastly, this is liable to occur during the puerperium. After they have reached the cavity they again remain stationary, and probably are only carried into the tubes from the causes already mentioned, the puerperium being the most favorable time, as the proximal openings of the tubes are then more patent. In fifty-three patients with gonorrhœa, who were kept under observa-

tion for at least five months after the initial symptoms developed, the cervix was infected in 75 per cent., the corpus uteri in 15 per cent., and the tubes in only 3.5 per cent.—*Boston Med. and Surg. Jour.*

#### THE DOG.

A sanitary exchange is responsible for the following assault upon this noble animal:

There is one sanitary evil, a source of great danger to human life and happiness—a standing menace to society, which, however, seems never to have occurred either to our sanitarians or our law-makers—the *dog*.

The State puts a price upon the head of the harmless coyote and jack-rabbit—harmful alone to agriculture and the stock interest,—every species of wild beast is proscribed, and properly, and they are being exterminated. The snake is the Ishmael of the earth—every man's hand is against him. Is the snake—the dreaded rattler or the deadly adder—more *useless* to society, or more deadly than the dog? Every domestic animal can show a *raison d'être* except the canine curse, the “cur of low degree.”

It were needless to specify the various uses to man, in his domestic life, of the horse and cow, the sheep and the goat; they are either laborers and servants, or else supply man's wants; but, let us ask, of what use is the cur dog? He is a thousand times worse than useless. He is a consumer, and contributes nothing, either to the support, comfort or happiness of man; but on the contrary, it can be shown that he is a source of constant danger to society in many ways.

What the dog consumes, properly economized, would relieve the sufferings of whole nations in times of famine. They rob women and children of bread.

The pretext for keeping a dog or dogs is protection to families. We challenge any man to name a well authenticated instance where a savage “yard-dog” has ever bitten any burglar, thief, tramp or incendiary; or that he has ever bitten any other than innocent persons; most frequently women and children.

It can be shown that the dog is often a factor in the development of the tape-worm, or of other human entozoa, perhaps of the deadly *trichina spiralis*; but it is not within the scope of this paper to go into details under this head.

Omitting the nuisance peculiar to this *genus*, fleas, a curse within itself, for which we are almost if not solely indebted to the dog, we will proceed to speak of the danger of dogs in all communities, in light of which the foregoing objections are insignificant: the propagation of *rabies*, improperly but popularly called “hydrophobia.”

#### LOCAL ANÆSTHESIA FOR SLIGHT OPERATIONS.

For operations upon small abscesses, opening fistulous tracts, or removing superficial growths, it is recommended that local anæsthesia be secured by a spray of the following solution:

℞.—Chloroform	10 parts.
Sulphuric ether	15 parts.
Menthol	1 part.
	—M.

The anæsthesia which is thus obtained lasts from two to ten minutes.—*London Med. Record.*

#### MEDICAL PRACTICE IN JAPAN.

The total number of physicians in Japan at the end of 1888 was 40,940; an increase of 61 as compared with the previous year. At the end of 1889 the number was 41,405, which is an increase of 465 as compared with the previous year. This increase is, however, only apparent, as, in proportion to the increase

in population of the country there is a falling off in the number of physicians. The total number of midwives at the end of 1888 was 30,860, which was an increase of 997 as compared with the previous year. At the end of 1889 the number was 32,111, which was an increase of 1,251 as compared with the previous year. When compared with the several previous years there is seen to be a gradual but steady increase year after year. The number of hospitals in 1888 was 504, an increase of 48, of which one was public and 47 private, as compared with the previous year. In 1889 the number was 573, of which public hospitals had increased by 3, and private hospitals had increased by 12, as compared with the previous year.—*Sei-I-Kwai Medical Journal*, September 26, 1891.—*Med. Rec.*

#### SEPTIC DISEASE OF THE UMBILICUS.

Eröss, from a study of the temperature of 1,000 infants born in the obstetric clinic at Buda-Pesth, comes to the conclusion that septic infection from the navel in association with detachment of the umbilical cord is a frequent cause of fever and an important element in the mortality of infants (*Weiner med. Woch.*, No. 41, 1891). Fever of longer or shorter duration was present in 450 cases, and in 220 it was due to a pathological condition at the umbilicus; gangrene of the cord in 81, sloughing in 55, protruding stump in 55, omphalitis in 24, ulceration in 3, and gangrene of the umbilicus in 2; death occurred in 8 cases. Waddington (*Journal of American Medical Association*, October 10, 1891), reports two cases of tetanus neonatorum which began to recover immediately after the application of thorough antisepsis to the foul granulating protrusion at the umbilicus, combined with the internal administration of beta naphthol (gr. 1) and chloral hydrate (gr. 1). He states that he had previously met with six other cases of the disease, all of which were fatal; these six cases had been treated by sedatives, and not by antiseptics.—*Brit. Med. Jour.*

#### TREATMENT OF HICCOUGH.

The *Gazette Hebdomadaire* gives the following treatment for hiccough. The local treatment is to compress the phrenic nerve and the pneumogastric in the neck by pressure with the index finger, which will often cause immediate cessation of the spasms. The medicinal treatment consists in the administration of a coffee-spoonful of vinegar mixed with a little powdered sugar, or the following formula may be used:

R̄.—Subnitrate of bismuth	gr. xlv
Oxide of zinc	} aa
Valerianate of zinc	
Powdered calumba	
Powdered opium	gr. ss

Essence of anise, a sufficient quantity.

Mix thoroughly, and give half a teaspoonful of this powder in a wineglassful of sweetened water.

#### ASPHYXIA.

A doctor was called to a woman who, with her child, had been suffocated. "They are both dead," he remarked, "we can do nothing." The unfortunates were removed to the hospital St. Louis, Paris, where the same statement was made. The house-doctor, however, asked permission to try artificial respiration with insufflations of oxygen, alternated with hypodermic injections of ether. Four receivers of oxygen were used, and the young doctor worked over his patients for three hours before a sign of life was perceptible. He finally succeeded in saving



both patients. There was some sound sense in the saying of one of the Paris faculty: "Never admit as irremediable the death of an individual who has been asphyxiated, drowned or hanged."—*Med. Brief.*

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### Medical Items.

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Sir Edwin Arnold gave a reading in aid of St. Mark's Hospital, New York. The amount realized was \$1,203.73.

The odor of iodoform can be removed from the hands and other parts, it is asserted, by washing thoroughly with linseed-meal water.

Dr. Charles H. Cockey, of this city, recently saved the life of his little Scotch terrier pup, eight weeks old, which was apparently dead from strangulation by a piece of meat, by means of tracheotomy.

The University of Munich has offered a prize for the best thesis during the session of 1891-92, upon "Experimental and Clinical Investigations as to the Occurrence and Diagnostic Significance of Leukocytosis."

The great author and teacher, Dr. A. Jacobi, of New York, will assume charge of the *Archives of Pediatrics* at the beginning of the new year. This will be a rich addition to the field of medical journalism.

A one per cent. solution of beechwood creasote, in a decoction of hamamelis, with a slight addition of boric acid, is recommended as a specific in gonorrhœa. It is claimed that this will destroy the gonococci in two hours.

The Medical Society of the State of New York will hold its next meeting at Albany, February 2, 3 and 4, 1892. Dr. Seneca D. Powell, of New York; Dr. James D. Spencer, of Watertown; and Dr. Franklin Townsend, of Albany, have been appointed the Business Committee.

The Woman's College of Baltimore (a well-known institution under the care of the Methodist Church), is said to have decided to establish a preliminary medical course, preparatory to the medical course for women which is some day to be opened in connection with the Johns Hopkins Hospital and Medical School.

The medal presented to Professor Virchow, at his recent jubilee, measures 118 millimetres in diameter, and is made from eighteen-carat gold. The front of the medal bears a bust representation of Virchow in relief. The back is adorned with an heraldic design, the allegorical figure of medicine and pathology, microscopes, books, skulls, and an Egyptian mummy.

Lelior claims excellent results in the abortive treatment of herpes from the local use of one part of resorcin or menthol to 50 of alcohol. If there is much pain he uses gauze steeped in the following solution and covered with an impermeable dressing: Alcohol, 100 parts; cocaine hydrochlorate, one part; extract of cannabis indica, 10 parts; mint essence, 10 parts.—*Times and Register.*

At the annual meeting of the New York State Medical Association, held in New York on October 28-30, the J. G. Orton Prize of \$100 for the best short, popular essay on some subject connected with practical sanitation was awarded to Dr. Howard Van Rensselaer, of Albany, New York, for an essay on "Impure Air, and the Ventilation of Private Dwellings."

It is reported that the *Therapeutic Gazette*, one of the world's most sterling

magazines, will be put under the editorial control, on January 1st, 1892, of Dr. Hobart Amory Hare, the talented author and Professor of Materia Medica, of Jefferson Medical College (Robert Bartholow's successor). This is a most important announcement. Dr. Hare will be assisted by a brilliant staff, of which Drs. Martin and De Schinemutz will form a very able part.

Dr. Heguin, of Tourteron, affirms (*Union Méd. du Nord-Est*), that photophobia with dilatation of the pupil is a useful diagnostic symptom of whooping-cough in the early stage, before the cough has become characteristic. He cites three cases in support of this position; two of the patients were children and one an adult, and in all of them the symptom referred to preceded any other manifestation of the disease.

At the recent session of the German Socialist Congress, held in Erfurt, a new and revised platform was adopted, one plank of which demands "free medical assistance, including attendance at childbirth, free medicine, and free disposal of the dead." We do better than that in New York, for we not only give free medical assistance and free medicine, but also sometimes, if it happens to be an interesting case and several clinics are after it, a free ride to and from the dispensary. This is truly the home of the free.—*Med. Rec.*

That beer-drinking conduces to sobriety has been, and is still claimed. It is difficult to see how those who believe this to be a fact can explain the following statistics. The consumption of beer in Germany does not exceed half a pint per diem for the whole population; at the same time Germany is third in the consumption of distilled spirits, and the *Irrenfreund* is authority for the statement that drunkenness is becoming alarmingly prevalent in that country. In the year 1888, 516 men were admitted to the Vienna insane asylum. The insanity of 143 of these was directly and of 93 indirectly due to alcoholism.

The presence of arsenic and lead in the urine is not often detected, because in routine work no tests are made for these subtle poisons. As a matter of fact, after the administration of potassium iodide for three days, they can frequently be detected in cases where the chemical features would not arouse the suspicion of metallic poisoning. The enormous quantities of arsenic in many samples of wall paper suggests a prolific source of arsenical poisoning. D. H. Galloway found 24 *per centum* of the samples he examined free from this metal. 30 *per centum* contained more than ten milli-grams to each square meter. The many cases of recovery from obscure forms of debility by change of locality without change in food, air or water, suggests the possibility that cases of arsenical wall-paper poisoning are overlooked.

At the meeting of the Association of German Alienists, held in Weimar, September 18 and 19, 1891, there was unanimously adopted a resolution welcoming the introduction of a bill by the Government against drunkenness as such.

The resolution, which was adopted with great satisfaction, demands the confinement of habitual drunkards in hospitals under medical management and State supervision.

One clause of the bill which has, we believe, become a law, provides that drinks shall not be sold before eight o'clock in the morning, and never to known drunkards. As the mental physician, perhaps more than any other, is better placed for a full realization of the disastrous effects of habitual intemperance upon the integrity of brain and nerve, both in the habitué and his descendants, the action of the Association of German Alienists cannot be without a decided influence for good.

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## CONTENTS

### ORIGINAL ARTICLES.

The Rest Cure and the Cases to which it is Applicable. By G. J. Preston, M. D., Baltimore. 89

Report of a Case of Chronic Suppurative Osteomyelitis of Femur with Amputation. By F. C. Bressler, M. D., Baltimore. 94

### EDITORIAL.

The Physician's Hand-Writing. . . . . 97  
Will the Influenza Return this Winter? . . . . 98  
The Semi-Annual Meeting of the Faculty at Rockville. . . . . 99

### MEDICAL PROGRESS.

Florida as a Health Resort.—Aphorisms in Rhinology.—Myxedema.—Pilocarpine in Puerperal Eclampsia.—Artificial Coffee Beans.—The Climatic Treatment of Whooping-Cough.—Hygiene in Russia.—Latent Nephritis in Children.—Smokeless Gunpowder.—The Prognostic Significance of the Tubercle Bacillus.—How to Laugh at the Mosquito.—Stites' Test for Carcinoma.—Treatment of Diphtheria.—Medicinal Properties of Vegetables.—Parturition in the Savage Indian.—Appendicitis.—Wash Fruits Before Eating Them.—Arsenite of Copper on the Wane. . . . . 100

MEDICAL ITEMS. . . . . 109

## Original Articles.

### THE REST CURE AND THE CASES TO WHICH IT IS APPLICABLE.†

BY G. J. PRESTON, M. D.,

Professor of Physiology and Diseases of the Nervous System,  
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It is only recently, and largely through the work of Hodge, of the Clark University, that we have come to the knowledge of the fact that a working nerve cell undergoes structural alterations which can be demonstrated. Hodge's experiments on several of the lower animals show conclusively that stimulation of a nerve cell, as, for example, stimulating the cells of the ganglion of the posterior root by applying a weak electric current to the nerve, causes a vacuolation and actual loss of protoplasm. Theoretically, we would expect this, and these experiments are confirmatory. Moreover, it is shown that when a cell has been kept at work for some time by electric stimulation and its protoplasm has been used up, it will regain its lost material, will again store up protoplasm, if it is allowed to rest. Thus we have a certain material foundation for that plan of treatment known as the rest cure. It has taken us a long time to apply the simple principle of rest, so all-important in, and co-extensive with, the art of surgery, to other things than broken bones or sprained joints. We have come to see clearly, as Hilton has shown in such a charming manner, that the natural relief of pain is rest. Furthermore, we know that pain by no means always signifies disease at the point where the pain is apparently felt, since irritation along the course of a nerve is referred to its peripheral distribution, or irritation

†Read at the Semi-Annual Meeting of the Medical and Chirurgical Faculty of Maryland, Nov. 17-18, 1891.

of a center is referred to the peripheral distribution of the nerves which habitually convey painful sensations to such center. We have come to apply this principle of rest to deranged function or disease of many organs. When the stomach fails to carry on properly the process of digestion, whether merely from functional derangement or because of actual structural disease, we feed by the rectum, and thus put the stomach at complete rest.

When the kidneys are congested, we use the skin or intestine to do their work. When we have a severe neuralgia, sciatic neuralgia for example, we put the nerve at rest by immobilizing the muscles to which the affected nerve is distributed. Finally, when it is evident that the nerve centers are exhausted by over-work or by work under great stress, wearing work, we come logically to the rest cure. This exhaustion may, as has been already said, be the result of an actual loss of protoplasm or it may be simply an inability to work easily, and without undue fatigue, due to some change, perhaps in the nature of the cell substance. In either case rest is the rational means of relief. While, of course, this general principle must have been always known and to some extent utilized by the laity and the profession alike, it was not until the genius of Weir Mitchell collected, discovered and arranged the facts, enunciated and explained the underlying principle and systematized the methods, that it became practically available.

Although this plan of treatment has taken its name from the important principle of rest, we shall see that rest is by no means the sole, and in some cases not the most important, feature. In order to make this description as brief as possible we may consider the rest cure as made up of the following elements: isolation, rest, forced feeding and artificial exercise, which latter is effected by massage and faradization. Isolation should in most cases, and always in the bad cases, be absolute. The patient should not be allowed to see any members of the family or friends—no one but the doctor and nurse. This is practically impossible if the patient remains at home. I always insist on the patient being removed to a hospital or boarding house, and my experience has led me to expect failure when my advice in this respect is not followed. One of the advantages of isolation is that the patient is taken away from the sights and sounds that in so many cases have become well nigh intolerable. At home the mind of the patient cannot be at perfect rest. Every sound suggests a train of thoughts which are in the main disagreeable, or at least break in upon mental repose. Every jar in the domestic machinery finds its response in the patient's nervous system. It is impossible to keep such a patient in ignorance of the daily routine of the household, and the ringing of the door bell may furnish material for half a day's disagreeable thoughts. Just as we rigidly exclude the light from an inflamed eye, so we must keep the irritable nervous system, the exhausted nerve centres, free from every stimulus.

The room in which the patient is put should be of good size, airy and simply furnished. The amount of light to be admitted varies according to the tastes of the patient and the stage of the treatment. I prefer that at first the room should be moderately dark, though later on in the treatment, and in some cases from the beginning, a sunshiny room is best. The temperature should be kept at the same point and it is better to have the room too cool than too warm. In most cases, as I have said, the rule should be absolute that the patient see only the doctor and nurse. Sometimes, however, it is impossible to carry this out, and then it is best to let the patient see only one person at a regular time and for the shortest possible period. The most careful and judicious friend is very apt to undo some of the doctor's work at every visit.

In regard to the second element of this plan of treatment, and the one from which it takes its name, rest, it may be said that the extent to which it must be carried depends upon the individual case. A very important point to be always borne in mind is that each case must be carefully studied for itself. The previous mode of life, the habits, tastes, peculiarities of the patient, must be noted, so that the physician may be enabled to avoid certain sunken rocks which, without this knowledge, he might run upon and lose all. In the worst cases absolute rest must be insisted upon. The patient should be put in a comfortable bed and not allowed to make a single movement. Food should be administered by the nurse, the bed pan employed—everything done for the patient, who should be absolutely passive. There should be no connection maintained with the former life—even letters should be forbidden. After a few days, or sometimes only after a few weeks, reading may be allowed, the choice of the books being left to the doctor, who should be able to prescribe the right sort of book with the same readiness that he prescribes the suitable medicine.

In certain cases the rest should be only moderate. The patient may be allowed to lie on a sofa, and to perform certain duties. Even in these cases dressing and undressing, or anything that is fatiguing, should be done by the nurse.

The third measure, forced feeding, is one of the most important elements of the treatment, and one that requires great care in its application. Most of the cases that apply for this treatment are dyspeptic, have no appetite, and loathe food. It is well to have the diet very light for the first few days. Have the bowels well opened and allow the patient only a little bread and butter with a glass of milk two or three times a day. In a certain class of cases, mentioned especially by Playfair, in persons who are fat it is a good plan to reduce the flesh by moderate starvation and then put it on again by feeding. This seems rather irrational, but often works well.

After a few days of light diet, begin gradually to increase the amount of food and add highly nutritious articles to the dietary. A cup of strong coffee with a biscuit in the morning on waking, in an hour a substantial breakfast of steak, eggs, etc., in two hours a roll and a glass of milk, in two hours a stout lunch or dinner with a glass of ale or beer, milk again in the afternoon and tea or dinner at the close of the day. Another glass of milk before bedtime and a glass during the night.

In some cases we are compelled to give smaller quantities of food at shorter intervals. Of course this large quantity of food, and sometimes it is wonderful how much a delicate woman who has been living on slops can be induced to take, would not be assimilated without the vigorous exercise which is always prescribed at the same time. Alcohol is to be used sparingly; a glass of sherry and a biscuit once or twice a day—or, what is better, malt liquor at the midday and evening meal. In regard to the time of taking the heaviest meal, this depends very much on circumstances. If the patient has always been accustomed to late dinner, and is not kept awake by eating a large meal at the close of the day, it may be taken then, otherwise at midday, and the evening meal be a light one. As a matter of fact, the desirable thing is to give two or even three full meals a day, and these meals need not vary greatly. Sometimes we can give anything the fancy of the patient may dictate, at others it is necessary to use certain special preparations, as raw-meat soup, finely chopped raw or rare meat, partially digested food, etc. I prefer to get the patient as soon as possible on ordinary diet; rare beef, eggs, oysters, sweet-bread, soups and milk in abundance. In carrying

out the last element of this plan of treatment we must have a good nurse. This is often a very hard thing to obtain. The nurse must be suited to a certain extent to the patient, and it is very important that the nurse and patient get along well together.

In selecting a nurse, be sure that she will carry out to the letter the directions, that she is firm, cheerful and not too talkative; which is expecting a good deal of the ordinary woman. She should understand thoroughly massage and the use of the faradic battery. Massage should be begun a day or two after the patient comes under treatment. General massage with passive movement of the joints should be practised every day, beginning with a *séance* of 15 minutes and gradually increasing up to an hour or an hour and a half. This should be done in the morning, and so timed that the patient may have a sleep after it is over. In the afternoon the muscles should be all gone over with the faradic current. Every muscle that can be reached should be made to contract as vigorously as possible without causing too much pain. This apparent excess of passive exercise is very necessary if we are to carry out the forced feeding. As the patient begins to improve, which is often after a week, certain modifications may be made. Some very limited voluntary movement may be allowed, such as sitting up in bed for a few minutes. The patient should not be allowed to get up for several weeks. When the patient is allowed to get out of bed this should be done very gradually. At first only for a few minutes on the sofa, then longer. Then a walk across the room; and gradually increase until out-door exercise can be taken without fatigue. It is well to have the patient sponged every day with tepid water, and as improvement goes on, use the cold spinal douche, or the alternate warm and cold douche every morning. As was said before, the physician must learn by experience, and by the study of each individual case, when he can vary and how much he can alter these general rules to advantage.

When we come to consider to what class this treatment is applicable, we are beset by many difficulties. There are patients to whom it soon becomes intolerable and has to be abandoned. Again, there are patients who submit willingly but in whom no good results are produced. If after three or four weeks faithful application of the rules laid down no good results are apparent, it is useless, I think, to pursue the treatment further. The average length of time required is perhaps six weeks. I always make it a rule to tell my patients' friends, never the patient if I can avoid it, that the treatment promises the best results but that it is uncertain and tentative. It may succeed perfectly, it may fail entirely and no reason for failure be apparent. The typical case in which we can expect the best results is nervous exhaustion, nervous break-down, nervous prostration, neurasthenia, or whatever we choose to call this well-recognized condition. The patient has drawn too heavily upon her store of nervous energy. She—for women furnish most of the cases—has had children in rapid succession; has been harassed by small domestic worries; has overtaxed her energies by social duties; has had sorrow; has lived under too great strain or excitement; has striven desperately to keep up appearances. These are a few of the etiological factors. The daily rest is never quite long enough to restore the protoplasm which the working cell has used up. When the account is made up, every day shows a slight deficit, until the inevitable bankruptcy occurs. The typical case is too familiar to warrant any extended description. The patient is generally pale, with an anxious, pained, dispirited expression, which is characteristic, has lost flesh, has no appetite, is constipated, utterly unfit for any bodily or mental exertion. The slightest effort causes flushing of the face, sweating, vague, irregu-

lar pains, a sense of utter exhaustion. Very commonly pain is complained of in the back of the neck and sometimes extending down the spine. There is a tired feeling, which sometimes amounts to actual pain, in the limbs. Generally such patients will say that they experience no actual pain, but only a very distressing feeling of utter exhaustion, utter helplessness, which is increased by the slightest effort. The reflexes are very generally exaggerated and any stimulus, even the slightest, calls forth a response which is, out of all proportion, greater than such stimulus would warrant.

One is reminded of the exalted reflexes of the lower extremities after a transverse myelitis of the dorsal cord. The emotions are easily excited and are uncontrollable. The patient is utterly unable to exercise any self-control. The will power is in abeyance. In cases which correspond to this type we can almost certainly promise cure, and if we fail to obtain it, should suspect that the mode of carrying out the treatment has been at some point faulty.

Unfortunately we do not always have these pure cases. Very often we find a large hysterical element. Sometimes it is a purely emotional disturbance; at others hysterical paralysis, motor or sensory, or both, may be present. In proportion as the hysterical element predominates the case becomes more difficult to treat. More unfavorable still than the hysterical element is the hypochondriacal. Experience has taught me to be very cautious in recommending the rest cure when I can detect a marked hypochondriacal tendency. These patients cling to their delusions of disease of some of their organs with the tenacity of a paranoiac, and even though treatment may benefit them greatly so far as their general condition is concerned, the mental deflection is exceedingly difficult to straighten. Apart from the direct benefit which accrues from this mode of treatment, there is an indirect benefit that must not be lost sight of. I mean the strong mental impression that is produced by isolation and the strict discipline which must be enforced in the minutiae of the daily routine. This is in the line of the hypnotic suggestion, but is, I think, more valuable and more lasting in its effects. It is this element especially that is of benefit in the cases in which hysteria preponderates, and to a less degree in the hypochondriacal cases.

We are far too apt to neglect the influence of the nerve centres and their varying conditions upon the bodily functions, and are much too prone to look always for some local, some special cause to account for the condition. Now in women the tendency, I was about to say the fashion, is to ascribe all her ills to her uterus or ovaries or tubes. We are apt to disregard the close relation which exists between the higher nerve centers and the reproductive organs. Those of us who are accustomed to see many cases of neurasthenia or nervous break-down in the male, know how common it is to find spermatorrhœa and all manner of sexual perversions, and yet castration has never become a popular mode of treatment.

The unfortunate male cannot make use of a pessary, but it is amusing to see how universal is the custom in this class of cases of wearing a suspensory bandage. It is a significant comparison that any one may institute between the large number of cases of actual disease of the reproductive organs in the female without any marked accompanying neurotic condition, and the rarity of decided disease of these organs in the class of cases under discussion. Undoubtedly a diseased uterus or ovary may act reflexly upon the nervous system and produce more or less general disturbance, but certainly the reverse is far more frequent, namely, that an exhausted, irritable nervous system manifests its disorder peripherally in these organs so highly supplied with nerves, and between which and the nerve centres there exists such a close bond of union.

The time allotted for this paper permits only this brief summary of the principles of the rest cure, and the class of cases to which it is applicable. The point which it is desired especially to emphasize is, that there is a distinct and easily recognizable condition of nervous expenditure, nervous exhaustion, and that the logical and rational treatment of this condition is rest.

819 North Charles Street.

## REPORT OF A CASE OF CHRONIC SUPPURATIVE OSTEO-MYELITIS OF FEMUR WITH AMPUTATION.\*

BY FRANK C. BRESSLER, M. D., BALTIMORE.

The specimen presented for your consideration is of decided interest and belongs to that class of joint disease often met with in their incipency by the general practitioner and, unfortunately, often overlooked or ignored at this period, resulting, too often, in loss of function of the joint, or, as happened in this case, loss of limb in order to save life. The patient from whom this was taken has the following history:

When eight years of age, jumped off a shed, spraining his wrist, ankle and knee-joint. His knee remained painful for some time, but later apparently ceased. When about 12 years old he again noticed some pain in his knee joint while walking, and a physician was consulted, who said it was nothing and depended upon his growth and size. Nothing special was done until a few years later, when the limb began to swell posteriorly about lower part of femur. He, however, had not had entire freedom from pain since he last began to complain. He now consulted an eminent physician, who applied a plaster of Paris cast; this gave entire relief. The cast becoming loose, another was applied by his last physician's assistant. The latter applied it too tightly, in consequence of which a violent inflammation of joint followed. From this time on, his knee-joint remained swollen and painful. He now passed from the hands of one to another, finally passing into the hands of his last attendant or family physician, under whose care he has been during the last seven years. He began to fail in strength—becoming anæmic, œdematous, etc. He was treated for malaria and kidney disease, and positively assured that his limbs had nothing to do with his case, and, it was stated, that "as far as his limb was concerned he could live fifty years." The regular attendant gave up the case owing to some misunderstanding and I was called to attend. I found his condition as follows: Serous diarrhœa for months, varying from 20 to 40 stools daily. Profound anæmia, skin partook of a decided waxy cast. Œdema of extremities, strength almost gone. Had not been able to leave his couch for weeks; temperature 101; complains of feeling chilly, chiefly towards evenings; vomits occasionally, sleeps badly, very nervous, passes large quantities of amber colored urine, heart hypertrophied, spleen and liver enlarged. Examination of left knee-joint discloses a foul smelling wound, joint ankylosed, patella adherent, joint nearly twice its original size, a number of sinuses present leading to different parts of the joint. Limb very œdematous above and below the joint. Further inquiry elicits a good family history, even back to his great-great-grand-parents, all being long-livers. Our patient is at present 32 years of age, never had any venereal disease, has always been healthy except measles in childhood. I stated to him that in my opinion his whole trouble was due to his limb, which had induced amyloid degeneration of his internal organs, that his case was of a serious nature and if he desired to

\*Read at the 720th regular meeting of the Medical and Surgical Society of Baltimore, October 8, 1891.



live he would have to submit to having his thigh amputated, as in his present condition he could live but a few months. The dangers of the operation were told him, and if he was going to do anything it would have to be done very shortly.

Having been previously told by other physicians that his limb had no bearing on his present illness, he felt dubious as regards my sudden verdict, and asked for further advice. Dr. Chambers saw the case with me, and after a careful examination, confirmed my opinion. After due consideration, our patient concluded to undergo the risk. He was accordingly placed on proper tonics and foods and his limb was kept clean daily by antiseptic washes. Under this plan of treatment improvement took place for a time being, but his condition began suddenly to change and in a brief time he was back again into his former condition. Several years ago he weighed over 220 lbs., now weighs but 98. Urine on heating shows nearly all albumen. Diarrhœa so frequent as to compel him to keep on the vessel almost constantly. In short, he was a mere skeleton, "walking around to save funeral expenses." His precise condition was plainly told him, and if he was satisfied I would operate within a day or two. He consented. Preparations for operation were immediately begun. He was bathed, limb surrounded by cloths rung out in bichloride solution and antiseptis observed as fully as possible. On October 30th, 1890, at 11 o'clock, Dr. Chambers began to administer chloroform. Limb amputated by flap method, at junction of middle with lower third of thigh. Found that the inflammation had gone up the medullary cavity and involved internal circumference of shaft. This was thoroughly removed by a Volkman spoon, packed with iodoform gauze, flaps brought together and stump dressed as usual. Hot bottles were immediately placed around him.

Patient became conscious, suffered little from shock—in short, passed through a serious operation with comparatively no shock, a thing almost impossible, so it would seem, in a patient so broken down as this one was. He has frequently said to me that he knows less of shock to-day than he did before the operation. His condition after the operation remained good except vomiting a number of times, some insomnia, etc. His kidneys gave me no trouble, acting promptly and freely; his bowels, on the contrary, became constipated and he was annoyed considerably with flatulent distention, requiring a laxative to secure an evacuation. He steadily improved, nothing occurring especially, and at the present time gets around the city on his crutches without any inconvenience. His bowels are regular, having from one to three stools daily, feels elegant, appetite grand, has become robust and weighs 176 lbs. In this connection I might say that I examined his urine this evening and find it free from albumen by the heat test, and were it not for the rather low specific gravity, 1010, I would incline to think that our patient's kidneys have so improved as to look upon them as being comparatively well. On the whole, our patient has survived one year since operation, and, judging from his present condition, he looks as if he will see many more.

This interesting case teaches us several points worthy of our consideration. One of the most important consists in diagnosing correctly pains occurring around joints. They may mean a true sprain, but, again, it is well to remember that in the young the layer of cartilage between the diaphysis and epiphysis is a delicate anatomical structure, apt to become diseased from the slightest cause. This fact ought not to be lost sight of when joint pains are complained of, thus avoiding the error so frequently made in looking upon these pains as rheumatic,

growing pains, etc. There is no doubt but that the general practitioner, unfortunately, looks too lightly upon these joint pains, diagnosing them as rheumatic or sprains. By this oversight many cases of epiphysitis go on until decided pathological changes have been induced, necessitating operation, which could have been avoided, at first, by giving the joint absolute rest. There can be no doubt but that our patient's trouble in the beginning had been an epiphysitis, which, being constantly irritated, became a suppurative form, constantly progressed until it broke into the joint proper, there setting up a destructive change, plus amyloid degeneration of the distant organs, etc. Had this joint been properly rested at first our patient might have escaped an operation.

Another shield frequently used by physicians is the ambiguous term, "growing pains." It is a generally accepted thing, by the laity and some physicians, that children growing rapidly suffer with pains around their joints. With the exception of rheumatism, I am inclined to believe that the majority of growing pains mean tender cartilaginous layers between shafts and extremities; *i. e.*, congestion. Since their structure readily admits of morbid changes upon the slightest cause, and when we consider how violent the exercise of the young frequently is, it seems not a very difficult thing to induce an epiphysitis of a mild degree. Therefore it is well to recollect this, examine carefully, and if in doubt immobilize the joint for a time.

Another popular error is to believe a running sore is good to drain morbid matter from the system and if interfered with means death to the patient. Our patient was told that his diseased limb had nothing to do with his case and it should not be interfered with. In connection with this subject I wish to say a few words of caution, and that is, remember you may be called to see a child who has been taken suddenly ill with high temperature, delirium, etc. You may find it difficult to diagnose the case; it is well for you to look to the epiphyseal junction for a tender spot; if you find it, cut down upon it immediately and allow the pus to escape, as you are contending with a case of infectious osteomyelitis and if you fail to drain promptly your patient will die. I mean, when I make the above statement, that all other diseases having been excluded, and refer to it only toward you of its severity, rapidity and danger if not promptly discovered and treated.

Lastly, if a patient has an amyloid kidney, and urine nearly solid albumen, we still ought to give the patient a chance for living, since in suppurative bone disease, after amyloid changes have taken place, the case will advance and finally prove fatal. Such being the case, based upon the history and result of the case reported this evening, I think we are justified to undertake a serious operation in order to give the patient a chance for living.

1713 Bank St.

Gunpowder stains of the face may be removed by painting with biniodide of ammonium, distilled water, equal parts; then with dilute hydrochloric acid, to reach the tissues more deeply affected.—*Revue de Thérapeutique.*

The late Dr. William S. Thompson, of Warren, Md., enjoyed a great reputation among both his medical brethren and the laity on account of the almost uniformly successful issue of the typhoid fever cases submitted to his care. He gave few drugs, but relied chiefly upon the application of thin poultices covering the entire abdomen, which were continued throughout the course of the disease.—*Med. Rec.*

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BALTIMORE, NOVEMBER 28, 1891.

**Editorial.****THE PHYSICIAN'S HAND-WRITING.**

The mystery above mentioned may be approached from two points of view—that of the pharmacist, who has to fill the prescriptions composed by the doctor, and that of the printer, whose task it is to translate his occasional communication to the medical press into type.

The skill of the experienced pharmacist in reading and filling the prescriptions sent him by certain physicians is one of the seventeen wonders of the present age. A communication, which to the average mind conveys not the slightest inkling of an idea, is by our skillful friend deciphered at a glance and rendered, without the least hesitation, into terms of therapeutic potency. Why prescriptions should be written in such careless form is a matter worthy of reflection. Is it because of gross carelessness on the part of the writer; or is it, as the public is inclined to suspect, only a stratagem to prevent the patient or inquisitive friends from stealing the doctor's weapons or becoming too familiar with the mysteries of his noble calling?

In viewing the medical contributions which are presented to the printer in the hand-writing of such a physician, the latter alternative is excluded, for surely the writer cannot desire to mislead or confuse the type-setter. Can it be pure carelessness which leads to the production of such puzzling manuscripts? If the writer could only see the difference between the first proofs of a plainly written or type-written article and those of an article such as we are now criticising, and see what a struggle the proof-reader has to keep from swearing at the writer of the latter, perhaps for humanity's sake he would write more carefully.

But we believe that there is an evil underlying many cases of bad handwriting which has not received sufficient attention. We refer to the methods according

to which hand-writing is taught to children in the schools. If all hands had the same anatomical structure, the copy-book style and the customary rules of holding the pen would enable all conscientious pupils of good mental calibre to write rapidly with tolerable distinctness, if not with grace.

All hands are, however, not of the same anatomical structure. There are many persons in the community who can with only the greatest care and deliberation write plainly and smoothly according to conventional methods. Pupils in school should be tested not only as to their ability to write plainly at their leisure, but as to their ability to write distinctly and at the same time with rapidity. The object of the instructor should be to teach a method which shall be useful in after life, even at the expense of beauty. The hurried business man, and the woman full of distracting household cares, have not time to write deliberately; and the epistles indited by them are often both puzzling and unsightly. Many such persons are forced in middle life by the consciousness of such defects, to change their manner of writing and perhaps to hold the pen quite differently from the school method; one adopting a "back-hand," another holding the pen between the index and middle fingers or the middle and ring fingers.

The question naturally suggests itself, should not such disagreeable experiences be prevented by more careful training at school? We hope that in the early future, with the advance of "individualization" in the instruction of the young, all pupils in the schools will be examined as to their ability to write plainly at high speed, and that those pupils who cannot be taught to do so, will be instructed in other methods of sloping the letters or facing the page or holding the pen, found by careful observation and experiment to be suitable to each individual case.

With such precautions we believe that the miserable scribbling, now so common, which makes a friendly letter often as hard to understand as a treatise in a foreign language, and takes away half the pleasure of the reader, to say nothing of the possibilities of serious mistake, will be the mark of deliberate carelessness, to be resented as a slight.

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#### WILL THE INFLUENZA RETURN THIS WINTER?

This question is suggested by an announcement in the daily press that this epidemic disorder has reappeared in many country districts of France, and also in different parts of Paris. Many deaths have occurred among old people. Although the disease is threatening to put on a malignant form, its influence on the general death-rate cannot be estimated until we hear how the strong and active members of the community are affected. It is to be hoped that its type will not be as severe as during the two years past.

The information of the return of influenza in France is of interest to the physicians of the United States, as indicating that this world-embracing "influence" is not yet ended. If it is to afflict the world again this winter even in a modified form, it is well that practitioners should be on the watch to detect its presence;

for the disease may appear with new manifestations now, as its symptoms have been so shifting and so manifold in the epidemics of recent years.

It cannot be disputed that influenza has introduced very disturbing elements into clinical diagnosis. Wearing at different times and in different patients the guise of bronchitis, pneumonia, phthisis, catarrh of the intestines, functional disorder of the heart, rheumatism, common fever, or disease of the brain and nervous system, it must give rise to many faulty diagnoses, and to much inefficient or injurious medication. Already we have reason to suspect that its subtle force is at work in this community; for some patients will tell us that the "cold" from which they suffer makes them feel very much as when they had the influenza.

Surely no physician of experience will desire the return of the epidemic in its severity. The members of the medical profession had certainly their share, in recent years, of suffering and inconvenience in their own persons or in their family circles. Those physicians in large and comfortable practice not only were overworked, but must have lost their hold on many valuable patients and families, who could not obtain proper attention and so went to other doctors. The tediousness of convalescence, and resistance to ordinary medication, the unexpected complications, and awful depression of the nervous powers, which were due to the presence of the influenza poison, in very many cases of illness, were very trying to the doctor. Taking the increase of practice during the prevalence of the influenza with the marked decrease of practice which has followed it, it is questionable whether physicians, at least in certain districts of this city, have reaped financial benefit from its presence.

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#### THE SEMI-ANNUAL MEETING OF THE FACULTY AT ROCKVILLE.

Very gratifying interest has been taken in the meeting at Rockville, held there by invitation of the Montgomery County Medical Society, and the question is asked of us, "Was it a success?" We are very glad to answer with confidence that it was a decided success. The programme was well filled with papers of merit, so that the sessions both on Tuesday and on Wednesday were quite equal in interest to those of a city medical society. The Physicians of the Montgomery County Society and of Rockville extended a most cordial welcome to their guests from city and State, and labored faithfully to bring the meeting up to the highest standard. The attendance upon the exercises on both days was better than had been expected, perhaps better than at any previous autumn meeting of the Faculty. The large proportion of county members from the vicinity and from other parts of the State was very encouraging, as an indication of increased *esprit du corps* on the part of Maryland physicians.

Owing to unavoidable absence we regret that we cannot bear personal testimony to the merits of the more substantial feast held Tuesday night; but those who participated in it assert that both in the number of guests, in the interchange of ideas, and in the toothsome-ness of its viands it left nothing to be desired. The

limits of these lines of comment forbid a detailed review of the Address of Welcome, the President's Address, and the papers and discussions of the session. If feasible, we will be glad to present to our readers at least some of these contributions, which are now in the hands of the secretary of the Medical and Chirurgical Faculty for publication in its forth-coming Transactions for 1892.

On the whole, this semi-annual meeting in Montgomery County was one of the most hopeful indications yet observed of that good time which is surely coming, when each county of Maryland shall have its medical society, and when the physicians throughout the breadth of our State, gathered about the time-honored Faculty, now nearly a century in existence, shall be united in most intimate fellowship for the promotion of medical learning, for the ennoblement of medical character, and for the advancement of the PROFESSION to that position of dignity and of influence in the community which it is its right to hold.

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### Medical Progress.

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#### FLORIDA AS A HEALTH RESORT.

In the *Climatologist*, November, 1891, Dr. Wall closes an interesting series of articles upon this subject, summing up in a judicial spirit his conclusions in regard to the matter.

Within the last 20 years Florida has become the great winter resort for thousands who wish to escape the rigors of a colder climate. Many suffering with pulmonary diseases seek health in her mild and genial air. Of these latter some are benefited, while others are not; the degree of improvement depending much on the stage, progress, and acuteness of the pulmonary trouble. Even those who are not specially benefited in a curative sense are often benefited for a short time, and life is rendered a little more enjoyable by their being able to get out into the open air, and by thus escaping the irksomeness of confinement at their homes. The development of consumption is more dependent on the hereditary vice of constitution—the inherited predisposition to the disease—than on climatic conditions; and, therefore, it is the height of folly to place much confidence in the climatic cure of consumption. As a prophylactic in those inheriting the predisposition to the disease, or in its incipient stage—one hardly recognizable with certainty—a residence in Florida may be of benefit; but even in both classes of these kinds of cases, the writer has seen the disease develop and run a rapid course to a fatal termination.

Keeping in mind, however, the aphorism, as old as Hippocrates, that “a sick person should always leave the place where taken sick,” it might still be found helpful for the consumptive to seek a change of climate. But the profession, as well as the public, should understand that there is nothing specific in the air of a southern climate to cure consumption, and that the benefit derived is purely hygienic in enabling the patient to enjoy the open air in out-door exercise, by which it is hoped that the nutrition may be improved, and the vice of constitution resulting in deposition of tubercle in the pulmonary tissue may be eliminated. Of course, where the patient is already suffering with hectic fever, and the destructive processes in the lungs are pursuing a rapid course, open air exercise is probably out of the question, and little, if any, benefit may be expected. In fact, it would be preferable for such patients to remain at home with its comforts and the solace

of relatives and friends than subject themselves to the discomforts of travel and hotel life, in the vain hope of being cured. When the disease, however, is of slow progress and of a rather chronic character, with little, if any, febrile disturbance, much benefit may be found by spending the winter in Florida, and living mostly in the open air; in short, resorting to camp life in favorable weather. In such cases marked improvement is generally the rule; but, of course, there are exceptions to all rules.

To the vast majority of the valetudinarian class from other causes than consumption, the winter's sojourn in the mild marine climate of Florida will always be found a powerful adjunct in re-establishing the impaired health.

#### APHORISMS IN RHINOLOGY.

In the *Medical Mirror*, Dr. Loeb gives a series of terse cautions.

1. Don't forget that the turbinated bones lie upon the external wall of the nasal fossæ.
2. Don't forget that the nose has an important respiratory function, in addition to its function of olfaction.
3. Don't allow patients who are predisposed to "colds" to bundle their necks in cloths. That keeping the neck warm protects the throat, is a mistaken idea.
4. Don't expect a marked case of chronic hypertrophic rhinitis to recover by indiscriminate use of sprays. Cauterization is almost always necessary and efficient.
5. Don't promise to cure chronic atrophic rhinitis; say you can relieve it, if your directions are followed.
6. Don't forget that benefit and often cure may result from the local treatment of hay fever. Examine the nose carefully, remove all obstructive causes and remedy all indications of reflex irritation.
7. Don't overlook the possible, often certain, influence of septal deformities or nasal inflammation, in the production of throat disease. They may both act mechanically and reflexly.
8. Don't mistake a portion of mucus or discharge, which may persist in the nose, for a polypus. Wash and clean the nose carefully before an opinion is given.
9. Don't forget the relation of the Eustachian tube to the nose and pharynx; therefore be wary about prescribing a douche to patients who have or have had otitis media. At the first appearance of pain in the ear, discontinue all forms of douching the nose.
10. Don't omit the examination of the naso-pharynx in all chronic nasal troubles; you may discover some local condition demanding treatment.
11. Don't permit a mouth-breather to go untreated. Adenoids in the vault of the pharynx, the most prolific cause of mouth-breathing, can be easily removed. Their persistence in mouth breathing does harm in a multitude of ways and should therefore not be tolerated.
12. Don't prescribe potassium chlorate for every case of throat disease. Your patient has probably used it before applying to you, and has found it unserviceable.
13. Don't use a cocaine solution as a gargle with the knowledge of your patient. In acute pharyngitis or tonsillitis it is a most efficient agent, but it encourages a habit when the patient knows what he is using. Always add to such prescriptions the words "*non repetitur.*"
14. Don't call a case follicular tonsillitis, diphtheria, but be always on your guard, lest, despite your own assurance, you may be mistaken in your diagnosis.

## MYXŒDEMA.

A correspondent of the *Therapeutic Gazette* writes that at the annual meeting of the British Medical Association a very interesting paper, just published, was read by Dr. G. R. Murray on the "Treatment of Myxœdema by Hypodermic Use of Extract of Sheep's Thyroid Glands." The author was induced to make these experiments from consideration based on the results of some Portuguese surgeons, who found that, on introducing the fresh thyroid gland into the subcutaneous tissue of a myxœdematous patient (after the manner proposed by Horsley), very marked improvement commenced even on the day after the operation. This could not be due to the gland becoming vascularized, and so functional, but appeared rather the effect of absorption of the juice of the healthy gland. If this were so, similar beneficial results should follow injection of an extract of the thyroid without ingrafting of the gland itself. To test this, an extract was made from a perfectly fresh sheep's thyroid by the aid of glycerin and a .5 per cent. carbolic acid solution. The gland is cut up finely, and placed in a test-tube with one c.c. of glycerin and one c. c. of .5 per cent. carbolic acid. The tube is plugged and left for twenty-four hours in a cool place, after which the extract is obtained by expression, as a pinkish fluid, which should measure three c.c. This quantity of extract was used for a patient with well-marked myxœdema, in two equal injections, in the course of a week. After three months, during which five lobes of sheep's thyroid were used, the patient's condition was noted as very greatly improved. Œdema had to a great extent disappeared, speech was again almost normal, and the patient was able once more to enjoy life and take an interest in her surroundings. Treatment by this method would appear, therefore, to hold out great hopes of success, and Dr. Murray will presently, no doubt, give us the results of further experience. Possibly, also, he or some other worker may find out the chemical nature of the active substance in the glycerin extract.

The diuretic action of fresh thyroid juice has also been the subject of a note by Mr. Harry Fenwick, of the London Hospital. From observations of its action in two myxœdematous patients, he thinks that the juice of the thyroid gland has a powerful diuretic action. A similar action is exerted in cases of renal disease, but no effect is produced by the injections in cases free from kidney trouble. Mr. Fenwick obtained very marked improvement of his myxœdematous patients as a result of the injections. He thinks that his experiments go to show that the usual theory of the action of the diseased thyroid in this malady is incorrect; and that the state known as myxœdema depends rather on perverted renal functions.

## PILOCARPINE IN PUERPERAL ECLAMPSIA.

In the *Gazette Hebdomadaire des Sciences Médicales* for September 12th, Dr. Strisover adds to the experience of observers in this field the results of his use of pilocarpine in the treatment of eclampsia. By the subcutaneous injection of hydrochloride of pilocarpine the author has been successful in controlling the convulsions and preventing their recurrence in ten cases. The treating successively of such a number of cases without one death has led the author to the conclusions that pilocarpine is an antagonist to the eclamptic process; that feebleness of the pulse is not a contra-indication to the repeated injection of the drug, so long as the convulsions reappear; and, finally, that the condition of the pupils is to be relied upon as an index to the further accession of the convulsions or to immunity by the physiological action of the drug.—*N. Y. Med. Jour.*



## ARTIFICIAL COFFEE BEANS.

The manufacture of artificial coffee beans has, it seems, reached a stage of such importance in the United States as to compel the attention of the revenue officers. This is no new movement, indeed. It is now more than thirty years since the late Dr. Lindley, the botanist, presented to the director of Kew Gardens, London, a selection of carefully moulded artificial beans intended for mixing with the genuine article. They were made of finely powdered chicory and were an excellent imitation. The ordinary American artificial bean is, however, composed of rye flour, glucose and water, and is prepared to resemble in size and color a fairly good sample of roasted coffee bean. When mixed with the genuine beans these imitations acquire the aroma of coffee. It has been computed that twenty per cent. of the beans sold in the United States are artificial. The spurious beans can be made at a cost of \$30 per 1,000 pounds, which, mixed with fifty pounds of pure coffee, finds a ready sale. Coffee substitutes are also sold openly like butter substitutes—one firm making 10,000 pounds a week. The wholesale vender thus escapes the penalty of violating the adulteration laws, but the retailers who buy the substitute know what to do with it. In Germany an imperial decree has forbidden the sale of the machines for making the false berry. Until the prohibition they were largely advertised.

## THE CLIMATIC TREATMENT OF WHOOPING-COUGH.

In an article upon this subject (*Climatologist*, Nov., 1891) Dr. Musser makes the following suggestive remarks:

All agree that cases which develop in our cities are benefited by change. Removal to the sea-shore or the country is generally followed by an amelioration of all symptoms. It is not necessary to discuss the benefit of such treatment. We all recognize its utility. It is of vital importance to discuss its practical possibilities. All recognize the difficulties which arise. Hotels refuse patients with the disease; private houses take them only on the fullest recompense. A certain class are debarred from climatic treatment by the expense attending it. Any one who has tried to get patients to suitable places will appreciate the difficulties and discomforts to himself and his patients. It is with the hope that the members of this society can now, or in the future, suggest and have established systematic means by which, to most persons, climatic treatment may be possible, and can be secured with a certain amount of comfort at a reasonable degree of cost, that the writer has ventured to bring up this homely but practical topic.

Is it worth while for this society to appoint a committee which might investigate the question involved and attempt to devise means whereby the benefits of climatic change could be secured to most of our patients?

Could a central bureau of registration or a directory be devised which at once could furnish all desirable information concerning health resorts and their accommodations for infectious diseases? This bureau need not be general. Each community might have one for resorts in its vicinity as each large town has a nurse's directory. Could and should this society attempt to get the authorities of properly selected points to build or encourage the building of sanitariums for the treatment of whooping-cough?

With a full appreciation of the practical importance of the subject, the writer submits the above for consideration.

## HYGIENE IN RUSSIA.

It is well that the citizens of this free country should pause for a moment now

and then in their indignation against the abuses of government service in Russia and consider whether in some respects that nation is not worthy of imitation.

In the *Union Médical* it is stated that the municipal council of St. Petersburg has built an immense filter by which all of the water supplied to the city is purified, has attended to the sanitary condition of the populous portion of the city, has furnished the poor with gratuitous medical attention, carefully provides for the analysis of food-stuffs and the study of their preparation, orders careful inspection of markets, restaurant-kitchens, etc., and in other ways looks after the welfare of the citizens of the capital. By these means the mortality of the city has been reduced 35.5 per cent. in ten years, it having fallen from 38.2 per thousand in 1881 to 27.2 in 1889.

#### LATENT NEPHRITIS IN CHILDREN.

An article in the *Medical and Surgical Reporter*, Nov. 21, 1891, by Dr. Léon, is well worth perusal. We can give here but a few extracts.

Lessening of the quantity of urine excreted was a prominent symptom.

In one half the cases the anuria was complete, in the rest partial and not stated.

None gave distinct evidence of nephritis before the suppression occurred. The nephritic symptoms usually appeared simultaneously with the anuria.

In those instances where the suppression was not absolute these symptoms developed gradually and insidiously, so that it was difficult to date their exact beginning. But whether insidious or absent, in all the cases the early prominent and only diagnostic sign of the renal disease was the anuria.

In only three cases were the post-mortem appearances noted. These presented three forms of kidney inflammation: acute diffuse nephritis, congestion of kidney and suppurative nephritis. The forms of nephritis in the cases without post-mortem history are unknown, but they were probably not the same in all cases.

Particular attention is called to the fact that these cases, with one exception, did not present that most common of symptoms of kidney implication in children—œdema.

The following general conclusions were therefore presented:

1st.—Latent nephritis, with suppression of urine, is a rare affection in childhood; not so in after life.

2d.—It occurs usually as a complication of some zymotic disease, chiefly scarlatina (as in all nephritis of children).

3d.—In these cases of scarlet fever it appears, usually, from the end of the second to the end of the third week.

4th.—It is sometimes impossible to foresee the nephritis—such symptoms as somnolence alternating with restlessness, slow pulse, vomiting, diarrhœa, headache and anæmia should always direct attention to the kidneys. But rarely these signs do not occur until after the suppression has set in.

5th.—Contrary to the rule in kidney disease in children, œdema must not be looked for in some cases, either before or after the anuria develops.

6th.—It is known anuria may exist with complete euphonia for several hours, perhaps for days.

7th.—No particular pathological variety of nephritis occurs in these latent cases.

8th.—The prognosis is bad—about three-fourths of the cases die.

## SMOKELESS GUNPOWDER.

The subject of smokeless gunpowder is briefly reviewed in the *American Chemical Journal* for November, 1891.

The first nearly smokeless gunpowder was probably that introduced by Colonel Schulze, of the Prussian Artillery. This consisted of small particles of wood, purified, partially converted into nitro-cellulose, and mixed with potassium chlorate. Within a few years much interest has been aroused by the report that the French government had secured the secret of a perfect smokeless explosive, a compound of picric acid; it has been supplanted by later discoveries.

The most successful modern "smokeless powders" are formed from the well-known nitro-cotton.

Nobel's smokeless powder, "balistite," consists of about equal parts of nitro-glycerine and soluble nitro-cotton, with the addition of a small proportion of camphor for the purpose of bringing about the combination of the materials; the effect of the camphor is also to greatly moderate the violence of the explosion. Another smokeless powder, "cordite," invented by Abel and Dewar, is a similar mixture of nitro-glycerine and ordinary gun-cotton, the combination of the two being brought about by the aid of acetone or other solvents; camphor or tannin is added to reduce the rapidity of the explosive action. These powders are similar to blasting gelatine in appearance, and are used in the form of small cubical grains. They are even more gradual in their action than gunpowder, and the rapidity of explosion can be modified to any desired degree by the addition of suitable proportions of camphor, etc. These powders are almost absolutely smokeless, and seem to be capable of successful use in small-arms or cannon. Experiments are now being carried on by several governments with a view to testing the efficiency of the new explosives, and determining the methods by which they can be most safely stored, transported and handled.

## THE PROGNOSTIC SIGNIFICANCE OF THE TUBERCLE BACILLUS.

Von Brunn, in speaking of the prognosis in cases of pulmonary phthisis, gives it as his opinion that it is preposterous to found an absolutely bad prognosis in any single case upon the finding of the tubercle bacillus. Kurlow has shown by inoculations in guinea pigs that the colonies of tubercle bacilli found in the chalky nodules and cicatrices in the apices of the lungs of dead people, who, during life, were always looked upon as examples of cured phthisis, can remain isolated and completely lose their virulence. These investigations speak in favor of Buchner's supposition that the body seeks to defend itself against the germs which have penetrated it, in that it builds up a wall of leucocytes against them by means of the inflammatory reaction, and that as a general rule this wall renders it very difficult for bacteria to spread, and that finally they undergo retrograde changes and are destroyed, only the scar tissue or chalky nodules remaining. According to Brunn's idea, this favorite result is brought about only when *few* bacilli make their way into the lungs; on the other hand, if the germs enter the respiratory tract in greater numbers, so much the easier will it be for them to break through the wall of leucocytes and infect wider areas of lung tissue or even light up a general tuberculosis. The appearance, then, of great numbers of tubercle bacilli in the sputa will render the prognosis somewhat more unfavorable. By way of an appendix, Von Brunn speaks of the connection of rapid aggravation in tubercular processes of the lungs with the operation for rectal fistula. Colonies of latent bacilli are set free by means of this operation, that is, freed from the leucocyte-containing wall; they then make their way into lymph blood-vessels and are enabled to infect organs in distant parts of the body. In

like manner, he explains such occurrences after operation upon fungous joints or scrofulous glands.—From a notice published in the *Canadian Practitioner*.

#### HOW TO LAUGH AT THE MOSQUITO.

“I notice that some one recommends the use of camphor against the mosquito nuisance. I have used camphor for this purpose for some time, though I have not found it necessary to burn it. I take a piece of camphor fully an inch square and half an inch thick; this I lay on the bureau—always exposed—in daytime, and on or near the pillow at night. This is the only remedy I ever tried that afforded thorough relief. Even a mosquito bar lets the mosquito in and bars the air out. Have two windows and door of the room wide open, no bars, and draft through. Have not been annoyed by mosquitoes since using the camphor, except to a very light extent for a night or two in case of storm and unusual draft through the room. I think then an additional piece or two of camphor would have prevented that. The mosquito has been a great annoyance to me, but I feel that I can now laugh at him. If others find the remedy as effectual as I have, it will be a boon.”

So writes an enthusiastic contributor to a contemporary journal. We wonder in which of the States of this mighty “Union,” the mosquito above referred to casts his vote. Did the writer ever make the acquaintance of a real Eastern Shore mosquito, of the race which sings its war-songs in the lonely cabin on the shores of the broad Chesapeake or swoops silently down upon the benighted traveler in those swampy lands? Many are the mighty deeds of valor accorded to him in history, not the least of which was his putting to flight a few years since a company of Johns Hopkins scientists, who, armed with all the weapons of civilization, ventured to moor their bark along his native shores for the purpose of studying the habits of the oyster. They prematurely decamped, bearing home with them the report that, unless something was quickly done, the Eastern Shore mosquito would soon equal the oyster of the Chesapeake in size.

We invite the writer to make a trial of his remedy. Let him, on some evening in late summer, penetrate into the favorite haunts of our mosquito along one of the sluggish rivers of our “lower counties.” Let him get out his lump camphor and place it near his pillow, as he opens his window to the soft night air, and if he does not toss with delirium to the tune of “My Maryland” or whatever other lay the invader chooses for his melodious even-song, and does not wake in the morning with a diffuse dermatitis, then we will admit either that he has some peculiarly disagreeable element in the composition of his tissues, or that the variety of mosquito which is the pride of our State has lost his virility, and deserves to be degraded to the condition of the “squaw mosquito,” like those of other States.

#### STITES' TEST FOR CARCINOMA.

In the *Medical News*, Oct. 31, 1891, Dr. Brinton gives a description of this new test. He says:

The new method of examination was that furnished me by Professor Chiene, of Edinburgh, which I give in his own words:—

1. Excise the mamma.
2. Wash thoroughly in water to remove the blood.
3. Place in a 5 per cent. solution of nitric acid (B. P.) for ten minutes.
4. Wash in cold water for five minutes.

By the time these procedures are executed the axilla is cleaned out and the vessels tied. The mamma is now examined; the carcinomatous structure ap-

pears a dull white, like the eye of a boiled fish, the healthy tissue translucent. When any such reaction is seen, additional tissue should be removed at the corresponding point.

In removing the carcinomatous breast, Professor Chiene directs that its relations to the circumferential tissues should be marked by the knife, so that after the test has been applied to the mass excised the situation of any outlying, unremoved diseased areas can be fixed.

In the case operated upon the foregoing directions were carefully followed by Dr. Coplin, who demonstrated to the class that the infected tissue became of the characteristic "dull white," resembling egg-albumen, while the uninfected tissue appeared translucent and gelatinoid, affording a striking contrast to the carcinomatous structures. The reaction in the axillary glands seemed even more marked than that in the breast; it therefore would, perhaps, be well always to retain one gland for comparison with those treated with the acid.

The test described by the distinguished Scottish surgeon as devised by his assistant, Mr. Stites, appears to be a most perfect one. It is to be hoped that future trial will show that it can be depended upon, and that it can really be accepted as a gauge of the thoroughness and sufficiency of removal of carcinomata, not only of the mamma, but also of other parts.

#### TREATMENT OF DIPHTHERIA.

From the editorial columns of the *Journ. Amer. Med. Assoc.* we extract the following suggestions:

A topical application to the affected part of a solution of one grain of bichloride of mercury, dissolved in four ounces of peroxide of hydrogen, at first recommended by Dr. Waxham, of this city, is a most effectual remedy.

In this connection, attention is directed to the easy and complete solubility of bichloride of mercury in glycerine, after which dilution to any extent may be conveniently made.

The acute symptoms of an attack of diphtheria being tided over, the avoidance of disastrous sequela may often be accomplished by a seemingly long continuance of the patient in a restful, recumbent posture, and a keeping up of the stimulants and extra diet.

From the very first indication of the presence of the disease, the patient should be as thoroughly isolated as possible; upon the perfection of this isolation or quarantine of the patient depends the ability to control the spread of the disease, and no matter how many cases a physician may have at one time, his efforts at establishing a complete quarantine of each one should never flag.

All expectoration and discharges from the throat, nose and mouth should be received upon paper napkins or pieces of tissue paper, and immediately burned. The soft Japanese paper napkins, which are so common and easily obtained, answer an admirable purpose as handkerchiefs for the sick of diphtheria or other infectious disease. Being inexpensive, after using they should be immediately burned.

#### MEDICINAL PROPERTIES OF VEGETABLES.

Spinach has a direct effect upon the kidneys.

The common dandelion, used as greens, is excellent for the same trouble. Asparagus purges the blood. Celery acts admirably upon the nervous system, and is a cure for rheumatism and neuralgia.

Tomatoes act upon the liver.

Beets and turnips are excellent appetizers.

Lettuce and cucumbers are cooling in their effects upon the system.

Onions, garlic, leeks, olives and shallots, all of which are similar, possess medicinal virtues of a marked character, stimulating the circulatory system, and the consequent increase of the saliva and the gastric juice promoting digestion.

Red onions are an excellent diuretic, and the white ones are recommended to be eaten raw as a remedy for insomnia. They are a tonic and nutritious.

A soup made from onions is regarded by the French as an excellent restorative in debility of the digestive organs.—*Journal of Balneology and Dietary.*

#### PARTURITION IN THE SAVAGE INDIAN.

Dr. Currier relates (*Brit. Med. Jour.*), that among uncivilized Indians the regular duties of the squaw are not long interrupted by parturition; and if her party is on the march she hurries on to overtake them after the birth of her baby. In some tribes it is the custom to facilitate the expulsion of the placenta by tickling the parturient's nose, thus provoking sneezing. The baby itself is managed on a kind of dry-earth system by the Crow and Assiniboine tribes; the umbilical cord is cut with a new butcher knife, the stump is well greased, and the infant is then thrust into a laced sack made of blue cloth, containing pulverized bull's manure or the inside bark of the cottonwood tree. This lining, with the child's discharges, is changed three or four times daily. When the stump of the cord drops off it is preserved in a beaded pouch, and worn around the neck or waist as long as the person lives.

#### APPENDICITIS.

In the *Courier of Medicine*, November 1891, an article by Dr. Price gives this summary of the symptoms of appendicitis:

1. History of sudden onset.
2. The point of greatest sensitiveness to pressure, exactly localized over the base of the appendix.
3. Fever as indicated by the thermometer varies, usually low.
4. Rigidity of right abdominal muscles, constant.
5. Constipation.
6. Œdema, overlying a deep abscess, in the right iliac fossa in neglected cases.
7. Shock, more or less profound, usually occurs where perforation happens early and suddenly; it is followed by chill, vomit, etc.

There are no special signs of perforation if it takes place late, after adhesions have formed. If perforation occurs late and the adhesions are imperfect, we find shock.

The symptoms should be studied most carefully at the end of the first twenty-four hours.

8. Pain is misleading; often referred to epigastrium alone; to umbilical region sometimes; it is often slight.

9. Tympanitis is variable; it depends on state of bowels; it indicates intestinal paresis—if it comes on rapidly it is unfavorable; it is often the result of opium.

10. Percussion not necessarily dull; there may be a tympanitic note from gas in overlying intestine.

11. Over-extension of right thigh gives pain.

12. Cough is avoided.

13. Tumor inconstant the first two days.

14. Pulse indicates severity and increase; it shows constitutional disturbance.
15. Chill and vomit inconstantly accompany the initial pain.
16. A prodromal stage of abdominal discomfort (about a week), is frequent.
17. Flexion of hip-joint not marked except in neglected cases.

The symptoms are not commensurate with the gravity, intensity and fatality of the disease.

#### WASH FRUITS BEFORE EATING THEM.

The following curious instance is reported in a French journal by M. Schnirer of the ease with which tubercle bacilli may be disseminated. While at work one day in the laboratory of Weichselbaum he sent for some grapes to refresh himself with. The fruit had been kept up for some time in a basket outside the laboratory, and was covered thickly with dust, so that the water in which it was washed was absolutely black. On examining the water he reflected that, inasmuch as the neighboring street was traversed frequently by consumptive patients going to the clinic, the dust probably contained the desiccated sputa of these patients, charged with tubercle bacilli. To settle this point M. Schnirer injected into three guinea pigs 10 cub. centim. of the water in which the grapes had been washed. One animal died in two days from peritonitis, the two others died on the forty-eighth and fifty-eighth days respectively, presenting marked tuberculous lesions, especially at the place of injection. The water in which the grapes had been washed was taken directly from the faucet, and the glass containing it had been sterilized; neither the boy who had brought the grapes, nor the merchant who had sold them, was tuberculous. Hence the cause of infection was beyond doubt the dust on the grapes. This experiment illustrates the danger arising from the dissemination of desiccated tuberculous sputa in the air. The conclusion is obvious: Wash grapes before they are eaten.—*Jour. State Med. Soc. of Arkansas.*

#### ARSENITE OF COPPER ON THE WANE.

So the *Northwestern Lancet* alleges. Its editor says:

“Arsenite of copper in the almost infinitesimal dose of one three thousandth of a grain repeated at short intervals, gained great credit in the treatment of dysentery through articles by Aulde, of Philadelphia, and others, written chiefly some two years ago. Lately much has been written on the other side, several physicians announcing that extended trials of the drug had shown that its use was attended with no more success than that following other and older plans of treatment. In short, the history of this drug in the treatment of dysentery is precisely like that of many another remedy that has been praised for its effects in this disease, and that is that those who have drawn attention to the new treatment have not taken pains to compare their results with those obtained by the use of remedies already in use, or more important still, with the course of the disease when left without medical treatment.”

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### Medical Items.

The College of Physicians of Philadelphia has awarded the Alvarenga Prize for 1891 to Dr. L. Duncan Bulkley, of New York, for his essay on Syphilis Insontium.

It is asserted that the antiseptic effect of corrosive sublimate solutions is greatly increased by heating to a temperature of 100° F. and higher, a 1 to 10,000 solution at this temperature being equal in germicidal efficacy to a cold solution of 1 part to 500.—*Med. Rec.*

To prevent sore nipples apply a mixture of tannin and glycerine, two drachms to the ounce, daily, during the last month of pregnancy. This renders the nipples tough, but elastic.—*Annals Hygiene.*

A convention of physicians held in Rockville, on November 17th appointed a committee to prepare a bill to regulate the practice of medicine in Maryland and to present it to the next Legislature for adoption by that body. The committee consists of Drs. J. McP. Scott, T. A. Ashby, Geo. J. Preston, W. F. Hines and Edward Anderson.

The physicians of Cincinnati have appointed committees to act together for the purpose of obtaining medical legislation this winter. The Academy appointed Drs. J. C. Oliver, T. V. Fitzpatrick and J. G. Hyndman; the Society, Drs. J. A. Thompson, F. W. Hendley and A. J. Miles; the Homœopathic Lyceum, Drs. J. D. Buck, C. E. Walton and C. D. Crank. Thus far no committee has been appointed from the eclectics.

A medical association has been started, with Dr. Senn, of Chicago, as its president, with the object of going together in a body to the meeting of the International Medical Congress to be held in Rome in 1892. The intention is to charter a vessel, which will take the party over and bring them back. It is expected that the trip will last six weeks, and that several places in the Mediterranean will be visited. The vessel will accommodate about 400 passengers.

The Medical Faculty of Cambridge University is now probably the largest medical college in England. The number of new students entering for full curriculum registered up to October 20th, in the larger colleges, were as follows: Cambridge, 119; St. Bartholomew, 104; Gny's, 91; St. Thomas', 83; St. Mary's, 76; Owen's College, Manchester, 66; Middlesex, 62; University College, 61; St. George's, 47; Charing Cross, 45; University of Durham, 44; London, 36; University College, Liverpool, 36; Queen's College, Birmingham, 36; King's College, 35; Yorkshire College, Leeds, 34; Westminster, 22; Oxford, 22.

The Montreal General Hospital will shortly receive the sum of one hundred thousand dollars, the benefaction being made in the will of the late George Chetwode Hamilton. This princely sum is left at the disposal of the Board of Managers, to be employed in such manner as will best conduce to the promotion of the work of the hospital. There are few cities that have been so highly favored as Montreal in the promotion and foundation of educational and charitable institutions. Hardly a month passes by without a bequest of some tangible kind being recorded. The late Mr. Hamilton's large-hearted benevolence will place the Montreal General Hospital in a position to further extend its usefulness.

Soon after the return of Dr. S. D. Gross from his visit to England, where had been conferred upon him the degree of D. C. L. by the Oxford University, it was our pleasure to congratulate him as being the recipient of so many distinguished honors and that this last seemed a fitting crown and recognition of a long and successful professional career. His reply was: Would you know the highest and most gratefully received compliment ever bestowed upon me? It was when I first visited Virchow's clinic; Virchow was at the time lecturing to the class. An attendant took in my card. Virchow looked at it and hastened to the door, where he greeted me, and bringing me forward with both my hands clasped in his, introduced me to his class as the Father of Pathology, and author of the first work ever printed on that subject, and of which he paid me a most profound compliment. I tell you that was one of the proudest moments of my life.—*Jour. Amer. Med. Assoc.*



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## CONTENTS

### ORIGINAL ARTICLES.

Report of a Case Illustrating the Diagnosis of Late Extra-Uterine Pregnancy and the Difficulty of Producing Abortion. By J. Edwin Michael, A. M., M. D., Baltimore. . . . . 111

The Urethra, Bladder, and Ureters During Pregnancy, Labor, and the Puerperium. By W. H. Parish, M. D., Philadelphia. . . . . 114

Notes on the Use of Coleine. By A. K. Bond, M. D., Baltimore. . . . . 119

### EDITORIAL.

Thanksgiving. . . . . 122

Maryland Physicians as Book-Writers. . . . . 123  
The Truth about Coffee. . . . . 124

REVIEWS, BOOKS AND PAMPHLETS. . . . . 125

### MEDICAL PROGRESS.

The Relation of Chorea to Rheumatism and other Diseases.—Sweet Oil for Gall-Stones.—Medical Treatment of Cystitis.—Leucoderma Syphiliticum. . . . . 127

MEDICAL ITEMS. . . . . 132

## Original Articles.

### REPORT OF A CASE ILLUSTRATING THE DIAGNOSIS OF LATE EXTRA-UTERINE PREGNANCY AND THE DIFFICULTY OF PRODUCING ABORTION.†

BY J. EDWIN MICHAEL, M. A., M. D.,  
Professor of Obstetrics in the University of Maryland.

There are few gynæcologists who, if put on their honor, will not be forced to admit that, some time or other, in the course of their practice they have been led either by false or careless statements on the part of patients or want of sufficient care on their own part, to introduce a probe into a pregnant uterus, thus running the risk of producing, even if they have not produced, an abortion. The tendency, and it is an extremely praiseworthy one, of later times to avoid the use of the uterine sound has made the accident much more infrequent than it used to be, and it is to be hoped that the greater conservatism with regard to the handling of the female generative apparatus which is so characteristic of the present day, will altogether abolish it. This accident is most apt to occur in cases where there is good reason not to suspect pregnancy by reason of the single state of the patient or by trusting too implicitly to the statements of married women. It must be admitted, however, that there are cases in which the practitioner may be led astray in spite of the greatest care. I once introduced a sound into the uterus of a patient about a week after an alleged menstruation,

†Read at the Semi-Annual Meeting of the Medical and Chirurgical Faculty of Maryland, Nov. 17-18, 1891.

and the resulting abortion revealed a four month's fœtus. The case which I propose to relate illustrates the manner in which this accident may occur, and at the same time the difficulty which is sometimes experienced in interrupting the pregnancy. The patient was a single woman, æt. 22, who was brought to the Free Lying-in Hospital of the University of Maryland, August 30th, 1891, with a diagnosis of extra-uterine pregnancy. The following history given by her physician in a letter to a neighboring practitioner will explain the case: "She is 22 years old. Menstruated in February and again on the 10th and 12th of this month (August). I commenced treatment on the 18th of May for *suppressio mensium*. Treated her with drugs five weeks, when she told me that she had a profuse vaginal discharge. Examined her and found her a virgin. No doubt about it. The sharp constricting band at ostium vaginæ never fools an intelligent practitioner. It was there in force. I stretched her vagina four different times with my finger before I could use a small speculum. Found a profuse muco-purulent discharge pouring out of the womb. I introduced a sound 4½ inches, swabbed with cotton until I got the uterine cavity clean, and then used Churchill's tincture freely, rotating the applicator so as to touch every part and parcel of endometrium. Did this 15 different times, 10 of which were daily. On the 10th of this month, passed a probe 6½ inches without her feeling it, and did not touch bottom. Her belly is growing rapidly and she has all the rational signs of being pregnant. Fœtal movements (or something like it), as active as any case you ever saw six months gone. Have not been able to hear fœtal heart. On left side in flank, is a steady thump, which you can both feel and hear, about four seconds apart, sounding like a tap with a tack-hammer and feeling like an aortic pulse. She denies most emphatically ever having allowed any intimacy either with man or boy. That her vagina has ever been entered by anything larger than my finger I certainly know, for no deception can be practised there on an old coon like myself. If she is pregnant it was gotten without intromission of the male organ and it is extra-uterine unless she has a *uterus bipartitis*, which I have made every effort to detect. The rough handling I have given her would, it seems to me, have ruptured any extra-uterine sac." It is proper to say that I was not familiar with this detailed history at the time of my examination, but was simply informed that the doctor had made the applications referred to in his treatment of the case and that he was quite positive in his opinion that the case was one of extra-uterine pregnancy. Professors Howard and Opie had already examined the woman and made a diagnosis of intra-uterine pregnancy and had wisely refused to allow the attending physician to prove his point, as he was very anxious to do, by the introduction of a sound. The case presented some obscure features and I gave it a very careful examination both with and without anæsthetic. The result of my examination was as follows:

Inspection revealed a somewhat asymmetrical enlargement of the abdomen, reaching about to the umbilicus in the median line, somewhat above it on the right and not quite so high on the left. The contour of the enlargement was slightly irregular. Palpation showed the fœtus to be in the right position, vertex presenting. There was an unusually small quantity of fluid present. The fœtal extremities were readily felt under the palpating hand as through a very thin covering. Movements were active. It was impossible at that time to elicit appreciable rhythmic contractions of the womb. Auscultation revealed fœtal heart sounds unusually distinct for the period of pregnancy with which we were dealing, and they were heard over a wide area, but most distinctly to the right and below the umbilicus. We were unable at any time to hear the uterine souffle. Vaginal examination showed a cervix hard and firm at the first

examination (without anæsthetic), soft and succulent at the later one. On passing the finger along the anterior wall a large, round tumor was felt, evidently the foetal head, and the cervix was not reached until this had been traversed. There was a distinct sulcus between this tumor and the cervix, and the first impression was that they were separate from each other. When, however, the cervix was seized by a vulsellum and drawn down the continuity of that structure and the tumor was made apparent. While the cervix was drawn down the finger could be passed up behind and the continuity of the cervix and tumor verified. Moreover, the absence of an empty uterus was demonstrated. The diagnosis of pregnancy in a sharply anteflexed uterus was therefore arrived at. The attempt to draw down the uterus was highly successful and besides giving the particular information sought showed in a very impressive manner the softening of the lower segment, which constitutes Hegar's sign. I communicated my diagnosis to the physician who had brought the case, but he declined to be convinced except by a birth *per vias naturales*. That interesting event occurred on the 18th of October last. Labor began on the evening of the 17th, at 9 o'clock. The patient suffered a good deal and pains continued active through the night of the 17th, and until midday on the 18th. The membranes ruptured early and high when the os was dilated to the size of a quarter dollar. Os remained rigid. At 11 on the night of the 17th, and at the same hour on the morning of the 18th, 20 grs. of chloral were given. Little or no effect was produced by the treatment. In the afternoon of the 18th the patient became much exhausted and labor pains about ceased. The administration of 20 grs. quinine seemed, as usual, to infuse new life into the uterus, the pains were re-established, became more active, and about 6 P. M., a small, immature female child weighing  $4\frac{1}{2}$  lbs. was born. The lying-in was normal. The temperature did not reach 100 at any time. Mother and child did well and both left the hospital on Nov. 3rd, in excellent condition.

The interesting points in the case are the diagnosis and the difficulty in producing abortion. The peculiarities in the case are, it seems to me, fully explained by the state of affairs discovered. The absence of the uterine souffle can be readily explained by the ante-flexion of the womb, for in this way the communicating branch between the ovarian and the uterine artery, the so-called puerperal artery, was pushed well back and out of ear-shot. The same fact shows us the fundus of the uterus instead of its anterior wall under the palpating hand and explains the difficulty with which appreciable rhythmic contractions were elicited and the apparent nearness of the foetal parts to the examining hand.

Why did not such radical treatment produce an abortion? The only answer I can give was revealed to me in my examination. When I drew down the cervix for examination I confess that I was surprised at the ease with which it yielded to traction. The softening of the lower segment was greater than I was prepared to meet. Now the ante-flexion was very acute. The operator in making his application made it to the posterior wall of the lower segment stretched out by traction and was thus prevented from making a direct attack upon the ovum. If the canal of the cervix had retained its normal relation to that of the body of the uterus I am convinced that less than fifteen applications would have saved my friend, the doctor, from making an erroneous diagnosis of extra-uterine pregnancy.

THE URETHRA, BLADDER, AND URETERS DURING PREGNANCY,  
LABOR, AND THE PUERPERIUM.†

BY W. H. PARISH, M. D.,

Professor of Obstetrics, Dartmouth Medical College; Professor of Anatomy,  
Woman's Medical College of Pennsylvania, etc.

The condition of increased vascularity and irritability of the urethra, bladder and ureters during pregnancy is due in part to the pressure of the uterus, and in part to the alterations in the general pelvic circulatory and nervous conditions awakened by the stimulus incident to gestation.

The bladder in early pregnancy is less capable of distention in the antero-posterior direction, and its enlargement is chiefly lateral. Later in pregnancy the enlarging uterus draws the bladder upward above the pelvic brim. The changes in the position of the bladder during pregnancy doubtless determine to some extent more frequent, and at times annoying micturition, yet the elevation of the bladder above the brim is a conservative provision, for in this way the bladder is largely protected from harmful pressure during normal labor.

However, the utero vesical ligaments are so unyielding that the bladder participates in such abnormal displacements of the uterus as occur during the pregnant state; for instance, it follows the uterus in procidentia, and is drawn downward and backward in retroversion of the gravid womb. The urethra becomes elongated with the elevation of the uterus, and in early pregnancy if uterine prolapse occurs, and also in advanced pregnancy if the uterus drops into the true pelvis, the upper portion of the urethra curves backward and downward, constituting dislocation of the upper third of the urethra, with the symptoms pertaining thereto.

With the changes in the position of the bladder, the lower portions of the ureters necessarily change in position, but these tubes suffer chiefly from pressure of the pregnant uterus, and, as a consequence, they, above the point of pressure, often become dilated to the size of the finger or of the thumb. The blocking up of the urine in the ureters influences the renal condition unfavorably, and doubtless, at times, contributes in the production of urinæmia and eclampsia. The pressure exerted upon the ureters suggests the advisability of repeated recumbency, or, better still, of the knee-chest position, during advanced pregnancy. When peri-uterine adhesions, with uterine displacement, exist, there is still greater risk of injurious compression of the ureters, and of eclampsia.

Mild cystic catarrh, some say inflammation, is of somewhat frequent occurrence during pregnancy, and may be the cause of albuminuria when the amount of albumin in the urine is small.

Hæmaturia occasionally occurs, because of the impeded pelvic circulation. A varicose condition of the bladder and urethral veins, usually with a like condition of the anterior vaginal wall and of the vulva, may arise, and be the cause of hæmaturia, with frequent urination and pelvic distress. This morbid vascular condition calls for rest during pregnancy. After labor it usually disappears, but when subinvolution occurs, it may become persistent.

When cystitis, even of mild type, exists during pregnancy, its careful treatment is strongly indicated, for labor and the lying-in are very prone to aggravate the inflammation. Especially is this true if the cystitis is of gonorrhœal origin. It has been observed also, that when cystitis exists during pregnancy, subinvo-

†Read before the Philadelphia County Medical Society, Nov. 11th, 1891.

lution of the uterus is very apt to occur, and the inflammation is very liable to become chronic.

In retroversion and incarceration of the gravid uterus, the lesions produced in the urinary apparatus constitute the most serious morbid changes incident to this grave complication of early pregnancy. Ischuria is the earliest, and one of the most important symptoms. The early compression of the urethra by the uterine cervix produces œdematous swelling of the urethral wall, with at first partial obstruction to the exit of urine. The pressure instituted by the enlarging uterus increases until urinary retention occurs, accompanied, it may be, with dribbling of urine from the over-distended bladder. The retained urine rapidly undergoes ammoniacal decomposition, and cystitis becomes an early complication. The inflammatory action produces diphtheritic flakes over the mucous membrane of the bladder, with erosion and ulceration. Absorption of the decomposed urine occurs with constitutional symptoms.

The mucosa may be cast off from the entire bladder, but especially from the portions of the organ above the neck, showing that this separation of the mucous membrane is due to the degree of congestion and of inflammation, rather than to direct pressure—for the pressure is greatest at the neck. I have seen large portions of mucosa cast off and blocking the urethra. It is stated that the separation of the mucous membrane is not likely to occur before the sixth day of the incarceration.

In some instances portions of the muscosa have been thus separated, and gangrene of the entire thickness of the bladder wall has occurred. Owing to the retention, the ureters become greatly and the renal pelvis moderately dilated. The inflammation extends along the ureters and invades the kidneys. The suppression of retention also occurs with constitutional manifestation.

In the over-distention, the bladder wall, though thinned at points, becomes remarkably thickened throughout most of its extent, and in a few days, even when entirely empty, will present to the palpating hand a firm mass, wonderfully like the non-pregnant uterus, and may mislead the examiner into supposing that the uterus is empty, and that a retro-uterine tumor exists.

In some instances the distended bladder has reached even to the ensiform cartilage. Rupture of the bladder has occurred, especially in the attempt at replacement. As an essential preliminary to replacement, the bladder must be emptied either with the catheter or by aspiration. When the over-distended bladder is being emptied, a bandage should be drawn firmly around the abdomen to lessen shock, to prevent the entrance of germs with atmospheric air, and to prevent hæmorrhage from the cystic vessels.

Paralysis of the bladder accompanies the over-distention, and catheterization will be necessitated at intervals of six hours after replacement, otherwise distention will again occur, with danger of a reproduction of the uterine displacement. Irrigation of the bladder will be indicated for several days, for the cystitis and ascending ureteritis endanger life after the uterine displacement has been corrected.

In the original production of retroversion of the gravid uterus, an over-distended bladder probably has very little influence, except in instances in which retroversion preceded pregnancy, and in other instances in which superior adhesions prevented the distending bladder enlarging upward.

When we study the relations of the bladder to labor, we find that in an entirely normal delivery the bladder does not usually impede labor, and labor does not interfere with the integrity, or injuriously with the functions of the bladder. For,

in addition to the elevated position of the bladder at the end of pregnancy, the frequent micturition of labor is conservative, for thus the bladder is kept so nearly empty that its presence is in no manner harmful.

Should, however, œdematous swelling of the urethra, or the immediate effects of pressure, or perverted nerve-action lead to distention of the bladder, parturient expulsive efforts are rendered feeble and less efficient, and the presentation or position may be modified unfavorably.

In neglected cases, an over-distended bladder becomes a grave complication, partly in the same manner that it does in incarceration of the pregnant uterus. A distended bladder may contribute also to the formation of a fistula, or to rupture during expulsive or extractive efforts. In rupture, the tear usually occurs in the posterior wall and into the peritoneal cavity, though it may occur anteriorly, and, in the latter case, if low down may give rise to infiltration of the anterior abdominal wall. Collapse accompanies rupture of the bladder, and if urine escapes into the peritoneal cavity, a fatal result is very probable. Under such circumstances cœliotomy would be urgently demanded, with trimming and suturing of the lips of the rent, and careful toilet of the peritoneum.

Rupture of an over-distended bladder has occurred during expulsive efforts in an abortion at the third month of gestation, even when there was no incarceration of the uterus.

Cases of cystocolpocele, or prolapse of the bladder, usually with distention, have occurred during labor, impeding delivery, and leading to the erroneous diagnosis of the bag of waters, or of a fluid pelvic tumor. Under such erroneous diagnosis the bladder has been incised or punctured *per vaginam*. A knowledge of the possibility of such a complication should lead to an easy diagnosis with the catheter carried into the bladder.

The downward dislocation of the upper portion of the urethra which sometimes occurs as the uterus enters the pelvis near the end of pregnancy may be further aggravated as the head descends, or when, with the forceps, a large head is pulled through the pelvic canal before moulding has occurred. This condition of the urethra is often associated with partial prolapse of the bladder, but both conditions usually disappear after labor if proper involution occurs, but may be persistent in subinvolution, and especially when united laceration of the perineum exists.

Undue distention of the bladder rarely occurs during labor, except in the second stage, and is then usually dependent upon pressure of the presenting part upon the urethra and the neck of the bladder. When an anæsthetic is administered during either the first or the second stage of labor, retention may arise, and be due to the obtunding influence of the anæsthetic. It should also be remembered that the secretion of urine is increased during labor, and the bladder may become filled rapidly. Sometimes, when spontaneous urination seems impossible in the recumbent posture, an attempt to urinate while sitting and between the pains will relieve the retention and obviate the necessity of catheterization, unless the head is fixed in the pelvis. When catheterization is necessitated during labor the simple precaution of pushing up through the vagina, in the absence of pain, the presenting part is too often overlooked, with the result of always endangering the integrity of the urethra and bladder mucous membranes, and sometimes of failing to introduce the catheter.

In neglected cases it is occasionally necessary to resort to suprapubic aspiration of the bladder during labor, but before this is done one should call to his aid the relaxing influence of anæsthesia, and the favoring latero-abdominal and genu-pectoral positions.

Prolonged pressure, especially of the foetal head, or occasionally of any part of the foetus, endangers the integrity of the cystic, urethral and uterine walls.

Ninety per cent. of urinary fistulae are dependent upon injuries sustained during labor, and in most instances are produced by the prolonged pressure of some part of the foetus. An evidence of the truth of the latter statement is the generally recognized fact that since the more prompt resort to the obstetric forceps has become the rule of practice, urinary fistulae occur with greatly reduced frequency. The old practice of administering ergot during labor contributed, doubtless, in the production of fistulae, through its influence in bringing about continuous uterine contractions.

It is long sustained pressure that determines the sloughing from which the fistula generally arises. Although the general use of the forceps has promoted in many instances the formation of fistulae, yet I am confident that the judicious use of the instrument has been at times productive of such lesions.

The resort to the forceps when the head is movable above the brim, especially with a flat pelvis considerably narrowed, places in great danger the walls of the urethra, bladder and ureters. Also the too frequent mal-direction of the force exerted in traction with the forceps, as when this force is directed against the anterior pelvic wall, produces contusions and sloughing of the soft parts, including, at times, the walls of some part of the urinary apparatus. The contusion may be sufficient to produce a fistula, or it may less seriously yet injuriously affect the urinary structures.

Were the axis-traction forceps in universal use, as in my opinion they should be, the mal-directed and too great force so often resorted to in traction would be avoided, and consequently the pressure exerted would be less prolonged and less forcible. At times a fistula may result from excessive pressure exerted even for a short time, especially if the bladder is partially or greatly distended.

Prolonged or undue pressure during labor may also give rise to erosion or ulceration and inflammation of either urethra, bladder or ureter.

These structures are liable to serious injury during the performance of craniotomy, from being punctured with either spiculae of bone or with the perforator.

The performance of version and of extraction by the feet has resulted in rupture of a distended bladder, and in other instances in sloughing productive of fistulae, or of vaginal cicatrices which interfere with the functions of the bladder.

Vesico-intestinal fistulae have sometimes followed labor in cases of old adhesions between the bladder and some part of the intestinal tract.

In the performance of the classical Caesarean or of the Porro operation, the bladder and ureters should always escape injury, unless there exists a patulous condition of the urachus.

In a large proportion of the cases of coelio-elytrotomy, the bladder was opened into, and the danger of this accident occurring was one of the several good reasons why that operation quickly fell into disfavor.

Occasionally a calculus exists in the bladder during labor, and its presence at that time always brings considerable danger to the patient. It is advised by some to endeavor to push the calculus upward above the brim, but it seems to me that this procedure would often be impossible of performance, and would be always of uncertain benefit. Extraction through the urethra after dilatation, preceded, it may be, by lithotrity, would promise the best result. Or, if this were impracticable from the low and fixed position of the head, vaginal, or, possibly, supra-pubic lithotomy, would be indicated. If the stone could not be carried

above the brim the supra-pubic operation would not be possible. I can scarcely understand how the circumstances can be such as to justify the performance of craniotomy, the child being alive and viable.

During the puerperal period, perforation of the ureter, bladder or urethra may arise from ulceration or from sloughing due to injuries sustained during labor. In fact, most fistulæ do not appear until several days have elapsed. In some instances by judicious treatment, especially with vaginal antiseptic douches, such perforations may be avoided. This is effected by lessening the intensity of the ulcerative and inflammatory processes. The liability to cystocele may be lessened by proper observance of recumbency and by immediate perineorrhaphy, if indicated. The measures influential in securing due uterine involution may be said to be generally favorable to the establishment of a normal condition of the urinary apparatus.

The inability to empty the bladder, so frequently existing during the few days following labor, may be due to one or several causes. At times swelling of the urethral wall may be the principal cause, though I do not think that this is frequently the sole cause. Often the loss of support sustained by the bladder due to the emptying of the uterus occasions the retention, while in other instances recumbency is chiefly at fault, for not a few women are unable to urinate at any time while recumbent.

It is best that the bladder should be evacuated every eight hours after labor.

If the labor has been a normal one, it is safer for the patient to be placed on the commode without being on her feet than to use the catheter. Nearly always the sitting posture will enable her to urinate. The use of the catheter after labor brings peculiar risks. Septic urethritis, cystitis, ureteritis and nephritis, one or all, have certainly been thus produced, and not infrequently. The catheter often causes abrasion, and although absorption through the urinary mucous membrane in its normal condition must be exceedingly slow, yet when this membrane is congested, but especially when abraded, absorption readily occurs. Practically the physician is never certain that the catheter is aseptic unless he cleanses it himself, and even then he must have correct knowledge as to how the instrument can be cleansed. Many nurses are either careless or ignorant, and the catheter is not easily kept aseptic. Moreover, the catheter may be perfectly clean, and yet it may pick up from the external genitals, after labor, septic material, or material that will quickly become septic, and carry it into the bladder. The custom, still recommended in some text-books, of passing the catheter under the bed-covering, is exceedingly erroneous. If the catheter must be used, the genitals and urethral meatus should be exposed and rendered entirely clean, and the clean catheter should be introduced with the parts in view—for only in this way can one guard against the introduction into the bladder of foul material. Hence, unless the contra-indications are plain, the patient should be placed on the commode, or in a sitting posture on a vessel in bed, or in the knee-elbow position if she cannot urinate in a urinal or a bed-pan. After primary perineorrhaphy the patient should be permitted to urinate spontaneously while lying on the bed-pan, and immediate douching of the external parts will prevent decomposing urine from interfering with primary union.

A catheter should be perfectly smooth, and with small orifices near the distal extremity. Some writers prefer the gum catheter. The best is of glass, and each patient should have a new one. The glass catheter can be more easily and more certainly rendered aseptic than the gum. Cystitis after labor determines subinvolution—may lead to urethritis, and possibly to pyelitis, which may rapidly termi-



nate fatally, or become chronic, with eventual loss of life. An active inflammation of the bladder, especially after labor, may be productive of pericystitis or pelvic peritonitis and of pelvic cellulitis. Chronic cystitis in the female often dates back to the lying-in. Stricture in the course of the urethra, or at the meatus, also finds its origin in a post-partum urethritis, or in external ulceration.

### NOTES ON THE USE OF CODEINE.†

BY A. K. BOND, M. D.,

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The nature and therapeutic powers of codeine (or codeia), an alkaloid derived from opium, are fully discussed in the most recent text-books on *Materia Medica* and *Therapeutics*. It is not my purpose in this brief paper to go over the ground which is so thoroughly covered by these standard works, nor would you find entertainment and profit in listening to a condensation of their statements. My desire to relate to you some of my personal observations in regard to the value of this drug is prompted by the belief that experiences in the use of any important therapeutic agent, or notes in regard to the treatment of obstinate manifestations of disease, add greatly to the interest and profit of a medical convention when they are enforced by the personal enthusiasm of the speaker, and are carefully expressed in terse, plain terms.

The drug of which I now speak is by some physicians highly valued and much used; is by others considered inefficient and unreliable; and is to many still unknown except perhaps by name. It is probable that its use is limited to certain districts of our country. It has been more or less employed in therapeutics for a long time, but is only at the present day receiving from the general profession the attention which it deserves. The uncertainty in action, which formerly characterized it, was probably due to imperfections in its manufacture.

The sulphate of codeine, the salt of codeine usually prescribed by me, is a light, white powder, not so bitter as sulphate of morphine, and somewhat more expensive. It may be prescribed in pill or capsule, or in solution with syrup or water.

I have used it with great benefit in that peculiar irritable state of the digestive canal in which severe pains in the stomach or abdomen occur shortly after each meal, perhaps accompanied by a rapid evacuation of the bowels. I have recorded cases in which this condition had continued for several days. The administration of a grain of sulphate of codeine just before each meal quickly and permanently relieved this disorder, perhaps after the first dose, without causing any unpleasant symptoms.

I have employed the drug occasionally in mild inflammation or catarrh of the rectum, in the form of suppository with cocoa-butter. At times it has seemed to exert quite a soothing effect on the bowel, relieving the tenesmus; but of late I have usually added cocaine, making the suppository with 2 grains of codeine sulphate and  $\frac{1}{4}$  to  $\frac{1}{2}$  grain of cocaine, and so have not been able to estimate the effect of the codeine sulphate.

Some time ago it was my lot to treat a neurasthenic lady who declared that she could not take the ordinary opiates and anodynes without a variety of alarming symptoms. She vomited foods, and all medicines except calomel. For the pains in the back of which she complained, I ordered suppositories of codeine sulphate, 2 grains. Quick relief followed. On another occasion nervous symptoms and

†Read at the Semi-Annual Meeting of the Medical and Chirurgical Faculty of Maryland, Nov. 17-18, 1891.

insomnia, which baffled her doctors, were quickly cured by similar suppositories.

In these disorders of the digestive canal and pelvic organs the drug seemed to exert a soothing local influence on the parts, aside from any influence on the general nervous system.

In the spring of 1891, I was asked to see a hunch-backed woman, who suffered at intervals from moderate pains in the region of the spine and spinal nerves, sometimes preceding the formation of an abscess connected with the carious process in the spinal column. She has since my first visits been finding quick and certain relief from, or moderation of the pains, by the use of codeine sulphate in doses of one grain three or four times a day. She takes the drug only when the pains return, and relies exclusively upon it for relief.

In the treatment of disease of the respiratory tract in which pain, of not very great intensity, is a prominent and harassing symptom, I find that codeine sulphate usually gives relief to the patient without influencing the course of the illness unfavorably. Sometimes the addition of this drug to the cough medicine seems to greatly hasten recovery.

I have reserved for the last the notice of two conditions in which I have found codeine sulphate a most precious remedy. The *first* of these conditions is observed in old or otherwise healthy persons. I refer to those patients who wake each morning before day with a cough and lie sleepless until breakfast time, perhaps wrestling in agony with those gloomy trains of thought which sometimes afflict the aged. Often a patient of this class will refuse to take dietetic or tonic measures of relief, and will not consent to the use of a "sleeping" or "quieting" draught; and indeed anodynes are not generally to be chosen for such chronic troubles of the aged. A patient afflicted in this way will often find the greatest comfort in a "cough medicine" containing a quarter or half grain of codeine sulphate in a teaspoonful of syrup of tolu and water. Sometimes this remedy will, in a single dose at bed-time, cause the patient to sleep quietly through the night until the proper waking hour. If not, a dose of it may be placed at the bedside and taken at once if the patient wakes too early, causing her (for I have not found this trouble in males) to drop quickly off into pleasant sleep lasting several hours. I do not know any other drug suited to this condition, unless it be *cannabis indica*, which can be given in such an agreeable form. The whole life of the patient may be brightened by this simple remedy.

The *second* of the important conditions in which codeine sulphate gives most grateful relief is that in which a patient ill with pulmonary or laryngeal phthisis tosses all night with a frequent, irritating cough. To several such patients I have recommended the use of a pill at bed-time containing 1 grain of codeine sulphate with sufficient aromatic sulphuric acid to make the codeine sulphate wholly and readily soluble in the stomach. They found such great relief (being partly freed from the cough, and brought into a state of pleasant reverie, even when they did not sink into sleep), that they could not, during the remaining months of life, be induced to give up or intermit the remedy.

These observations have convinced me that we have in codeine sulphate a drug of very great value in a limited class of disorders, where an anodyne and hypnotic of moderate strength is needed.

It has certain disadvantages; its expensiveness, not so great, however, as to prevent even the poor from using it; its feebleness, for it cannot be compared to morphia as an anodyne, nor to chloral as a hypnotic; and its adaptability to the relief of only certain persons in the community. Perhaps four out of five persons find it a pain-reliever, or a remedy for irritating cough. I do not know

whether a large or a small percentage of patients would be lulled to sleep by it.

But in its own little sphere of usefulness it is almost an ideal remedy. Where it does no good, it certainly does no harm. Where it does benefit a patient once, it can be relied upon in future to repeat its kindly service. The great beauty of the drug lies in the fact that it produces its soothing effects without the slightest disturbance of the bodily functions. The bowels are not confined by it, digestion is not disturbed, the secretions of the liver and other glands of the digestive tract, of the lungs and bronchial tubes, are not checked. In consequence, perhaps, of this uninterrupted harmony of function, the dose of codeine sulphate does not need to be increased as time goes by. For the same reason, the remedy is specially suited for administration to the aged, who cannot afford to have their digestion upset by drugs. As far as I know, codeine and its salts do not give rise to a drug-habit. I have never observed any indication of an injurious habit in my own patients, and a prominent druggist familiar with the remedy tells me that he has never observed any undue desire on the part of customers to have prescriptions containing it repeated; nor do I recollect any well-authenticated case of codeia-habit recorded in literature. Every conscientious physician will appreciate the value of a soothing-remedy which does not produce a drug-habit; for the charge of leading patients into such habits is one of the opprobria of medicine.

I take pleasure in recommending codeine and its sulphate to the attention of those members of the profession who have not yet thoroughly tested its virtues.

#### THE LATEST NATIONAL ASSOCIATION.

By an editorial in the *New England Medical Monthly*, Dec., 1891, we are informed that the second annual meeting of the American Electro-Therapeutical Association, held in Philadelphia the third week in September, was quite successful. Among the most important subjects considered was the selection and adoption of a standard galvanic cell and faradic coil. Probably the most difficult question among physicians at large who are honestly anxious to use electric energy in their work, is the knowledge of what to buy in the way of a constant current battery or reliable faradic coil. For want of this, a large majority of practitioners are averse to using an agent whose unit is variable as far as medical use goes and whose effects have been thus far insignificant in their hands. There is no lack of general interest; on the contrary, as Dr. Hutchinson justly observed, it is difficult to find a physician's office in the land unsupplied with some form of electrical machine.

The people demand its use and doctors comply; unwillingly, perhaps, but only because of its uncertainty of result, not because they do not believe in its value.

When the committee to whom was assigned this standardization shall have submitted their report, and there exists a galvanic battery and a faradic coil whose potential is authoritative, it is easy to see how much more accurate and valuable electro-therapeutics will become.

The chairman of this committee is Dr. A. H. Goehlet, of New York. Papers were presented by Dr. Newman, on electricity in carcinoma; by Dr. Massey, on electro-puncture of uterine fibroids; by Dr. Morton, on a method of determining, by measurement of the progress of tissue-changes, how long the current should be passed in any given case; by Dr. Bigelow, on alternative currents; and by Dr. Hutchinson, on electrical diagnosis in disease by the variations of electrical resistance. Several new members of great repute at home and abroad were elected,

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BALTIMORE, DECEMBER 5, 1891.

**Editorial.****THANKSGIVING.**

At this season of the declining year when the people of the United States, led by their President, are acknowledging with thankfulness the many blessings which, as a nation or an assemblage of nations, they have received during the past months, it seems fitting that we, as physicians, should pause for a moment to consider the progress which has been made in those departments of medicine which are of national interest.

Most important of all is the establishment of official examining boards, in States heretofore destitute of means for excluding the vicious and the uneducated from the practice of the healing art. Progress in this line is slow, but it is evident that when a large number of States shall have established licensing boards, those which refuse to take the initiative in this matter will be forced to follow, by the necessity of protecting themselves against the outcasts of neighboring States. The profession of Maryland, of whatever school, may take its place with pride among those who have given their vote in favor of progress. That Maryland has no examining board is due, not to the negligence of the physicians, nor to the unwillingness of the people of the State, but simply to the personal decision of the Governor, which we hope will be reversed by his successor.

The standard of medical education in the colleges is steadily improving. The curriculum of all colleges, which even lay claim to respectability, will soon be fixed at three full annual courses of instruction. Improvements in the equipment of these colleges and more careful teaching in special departments of medicine are constantly being made.

The establishment of post-graduate courses in many great teaching centres in this country is a source of congratulation, whether such courses be taken instead of, or in addition to, clinical work in foreign hospitals, which has been in such favor for many years past.

The growth in numbers, culture and influence of local and national medical societies, is very encouraging.

Side by side with the medical societies move the great medical journals, which are now pressing forward in sharp competition with the best publications of foreign countries.

In the sphere of ethics it is most gratifying to observe that no signs of decay or decline are to be found. The tendency in some quarters toward effacement of the barriers erected against the various sects which have assumed distinctive names or claim to be possessed of infallible theories of therapeutics, is fully counterbalanced by the more thorough education and more intelligent practice of such physicians, and by the erection within their own bounds of codes of ethics and barriers against ignorance and quackery. In spite of the increase of competition and the corrupting influences which advance in age and in density of population brings to every nation, the medical profession, as a profession, still clings with fidelity to the exalted principles laid down by the fathers of our art in all the centuries of the past.

In the field of public hygiene great improvements are being made, especially in regard to the prevention of contagion, and the inspection of foods and drinks. Although Maryland is not abreast of some of her sisters in this matter, she will certainly be quick to adopt those measures which their experience recommends. The suggestion made in one of our great national medical societies, that the interests of national hygiene should be represented in the Presidential Cabinet of the nation, is worthy of careful attention.

Even this brief review indicates that, in its relation to the public and to the nation, medicine is steadily going forward—slowly, it is true, yet steadily—and encourages us, with grateful acknowledgement to the Author of all good, to renew with vigor our efforts for the advancement of our profession.

#### MARYLAND PHYSICIANS AS BOOK-WRITERS.

In view of the literary activity of the physicians of Maryland in the line of contribution to the medical journals and society publications of the country, it is somewhat surprising that more books are not issued by them. This is not necessarily an indication of lack of culture either in medicine or general literature, but rather a proof of the scarcity among us of men of a particular type of mind. For the book-writer is undoubtedly a peculiar species of the human race, differentiated by inheritance or by circumstance for a special service to mankind. He is usually but not always a member of the class of journal writers.

Some of our most promising literary workers, as Bartholow and Hammond, have been drawn away from us by the greater attractions of other cities, and have there made themselves famous by book-writing. Yet a few remain, and it should be our delight to honor them for their faithful labors. Within the lines of practical medicine the names of Dr. Rohé and Dr. Canfield and Dr. Simon (Medical Chemistry), deserve mention, nor should the work of translators, as the late Dr. Brune, be forgotten.

In the borderlands of medicine some good work has been done recently. The late Dr. Quinan's "Medical Annals" deserves high praise. The "History of the University of Maryland" by Dr. Cordell is another production of faithful historical research which, with that just mentioned, will command the respect and the gratitude of all future generations of physicians in Maryland. These two publications contain many valuable records which would soon have been forever lost. The physicians of our day seem not to appreciate the services and the enduring work of the men who labored in the past, in the face of the most discouraging opposition and apathy, to make our profession honorable and prosperous throughout the State.

Dropping in recently upon Dr. Cathell in his office, we found him busily engaged in the revision of his "Physician Himself," a new edition of which is soon to appear. This book, which, he once told us, is the embodiment of thoughts jotted down during his daily rounds and afterwards reduced to order, has been a great assistance and comfort to us, dealing, as it does, with the many small and great problems which the young physician meets in his business, social and professional relations with the public. We believe that this work is the only one of its kind published in America.

We are not sufficiently versed in the annals of general literature to know what efforts in the line of literary book-making have been put forth, either in past days or recently, by the profession of Maryland. It is but right, however, that we should refer to the happy hours spent in youth in poring over the pages of the "Gleanings for the Curious," one of a series of entertaining and instructive books written by our friend and fellow-citizen, Dr. Bombaugh.

With the advance of general culture in our profession, and with the founding of new medical schools and hospitals of the highest class in the city, or the introduction of more accurate methods of work and record-making in those already existing, we may expect a pleasing advance in professional book-work. Even now we are awaiting with eager expectation a book on Practice of Medicine promised by Dr. Osler.

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#### THE TRUTH ABOUT COFFEE.

The manufacture of an agreeable cup of coffee would seem to the physician a simple enough affair. Does not the pharmacopœia teach that the aroma and flavor of coffee are retained when it is prepared in the form of a hot infusion, and does not the doctor know all about infusions? But somehow his ideas do not seem to take with the female portion of his household. The coffee is either "sloppy" or "over-boiled" or of the wrong variety of berry. The doctor goes out to an entertainment at a neighbor's and has a "splendid cup" of coffee, served concentrated, in small cups, a perfect treasure-house of delightful aromas. Next day he enters on a domestic crusade. The housekeeper is coaxed or tormented into buying a new style of coffee pot, with patent fixings which put the cook into a temper. A new mixture of coffee grains is secured from the grocer,

and the result is watched with anxious interest. All is disappointment. The doctor retires in ill-humor, asserting that the women don't follow his directions, and the housekeeper and the cook unite in the firm resolve that the doctor shall not meddle again in the cookery. The coffee subject is regarded thereafter as a painful topic, which must not be brought up in domestic councils.

It is possible that the extensive adulteration with manufactured coffee grains has something to do with the matter. An English writer, however, suggests that the trouble is not with the cook, but with the coffee-drinker. Coffee, in his opinion, should be drunk, not simply in infusion, but in *concentrated* infusion. A dilute aqueous infusion of even the best coffee is nauseous and is made worse by the addition of large quantities of milk. He holds that coffee will never be a national beverage in England until the English learn to drink it in small quantities of a half ounce or ounce in concentrated infusion, as the Europeans of the Continent use it.

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### Reviews, Books and Pamphlets.

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*A Treatise on Practical Anatomy; for Students of Anatomy and Surgery.* By HENRY C. BOENNING, M. D., Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy; Demonstrator of Anatomy in the Medico-Chirurgical College; Demonstrator of Anatomy in the Philadelphia Dental College; Lecturer on Diseases of the Rectum in the Medico-Chirurgical College, etc. Illustrated by 198 wood engravings. F. A. Davis, Publisher, Philadelphia and London, 1891. Pp. 480.

The author states in the preface that this volume is not a compilation, but the result of years of practical work and teaching; the descriptions of the text being taken directly from the dissected body.

We find the volume to be neatly printed in fine large type. The wood-cuts are well printed and executed in such a manner as to bring out plainly the important points in the part described. A section on Regional Anatomy supplies a description of the neck, the axilla, the structure and relations of herniæ, etc. We take pleasure in recommending the work to the attention of our readers.

*Manual of Chemistry.* A Guide to Lectures and Laboratory work for Beginners in Chemistry. A Text-book, specially adapted for Students of Pharmacy and Medicine. By WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry and Toxicology in the College of Physicians and Surgeons, Baltimore, and Professor of Chemistry in the Maryland College of Pharmacy. New (third) edition. In one 8vo. volume of 477 pages, with 44 wood-cuts and 7 colored plates, illustrating 56 of the most important chemical tests. Cloth, \$3.25. Philadelphia: Lea Brothers & Co.; 1891.

*Ptomaines and Leucomaines and Bacterial Proteids; or the Chemical Factors in the Causation of Disease.* By VICTOR C. VAUGHAN, Ph. D., M. D., Professor of Physiological and Pathological Chemistry and Associate Professor of Therapeutics and Materia Medica in the University of Michigan, and FREDERICK G. NOVY, M. D., Instructor in Hygiene and Physiological Chemistry in the University of Michigan. New edition. In one handsome 12mo. volume of 389 pages. Cloth, \$2.25. Philadelphia: Lea Bros. & Co., 1891.

*The Medical News Visiting List for 1892.* Weekly (dated, for 30 patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for 30 patients weekly per year); and Perpetual (undated, for 60 patients weekly per year). The first three styles contain 32 pages of data and 176 pages of blanks. The 60 Patient Perpetual consists of 256 pages of blanks. Each style in one wallet-shaped book, pocket, pencil, rubber, and catheter-scale, etc. Seal grain leather, \$1.25. Philadelphia: Lea Brothers & Co., 1891.

*Saunders's Pocket Medical Formulary;* with an Appendix containing Posological Table; Formulæ and Doses for Hypodermic Medication; Poisons and their Antidotes; Diameters of the Female Pelvis and Fœtal Head; Diet-test for various Diseases; Obstetrical Table; Materials and Drugs used in Antiseptic Surgery, etc. By WILLIAM M. POWELL, M. D., Author of "Essentials of Diseases of Children," Attending Physician to the Children's Seashore-House for Invalid Children, and the Mercer House for Invalid Women at Atlantic City, etc. W. B. Saunders. Philadelphia, 1891. Price (Cloth), \$1.50.

*Announcement of the Sheppard Asylum.* A Hospital for Mental Diseases, Baltimore Md., 1891. Will be noticed in Editorial Columns.

*A Practical Treatise on the Diseases of Women.* By T. GAILLARD THOMAS, M. D., LL. D., Emeritus Professor of Diseases of Women in the College of Physicians and Surgeons, N. Y., and PAUL F. MUNDE, M. D., Professor of Gynecology in the New York Polyclinic. New (sixth) edition, thoroughly revised and rewritten by Dr. Munde. In one large and handsome octavo volume of 824 pages, with 347 illustrations. Cloth, \$5.00; leather, \$6.00. Philadelphia: Lea Brothers and Co., Publishers. 1891.

*Essentials of Nervous Diseases and Insanity—Their Symptoms and Treatment.* A Manual for Students and Practitioners. By JNO. C. SHAW, M. D., Clinical Professor of Diseases of the Mind and Nervous System, Long Island College Hospital, Medical School, etc. W. B. Saunders, 913 Walnut Street, Philadelphia. 1892.

*Electricity in Carcinoma.* By R. NEWMAN, M. D., New York. Reprinted from the *Times and Register*, Oct. 10, 1891. The American Medical Press Co., Limited, 1891.

*A Case of Fracture of the Twelfth Dorsal Vertebra;* followed by Injury to the Spinal and Sympathetic Nerve-supply of the Bowel in the region of the Ileo-cæcal Valve; Intestinal Hemorrhages and Death on the Seventh Day. By J. T. ESKRIDGE, M. D., of Denver, Col. *Medical News*, Oct. 10 and 17, 1891.

*An Abstract of the Symptoms;* with the latest Dietetic and Medicinal Treatment of Various Diseased Conditions; the Food Products; Digestion and Assimilation. By REED & CARRICK, New York, 1891.

*The Texas Sanitarian;* a Journal of Preventative Medicine and Hygiene. Published monthly at Austin, Texas, by the Texas Sanitarian Publishing Company. \$2.00 per year.

*A Manual of Practical Obstetrics.* By EDWARD P. DAVIS, A. M., M. D., Clinical Lecturer on Obstetrics in Jefferson Medical College, Professor of Obstetrics and Diseases of Children in the Philadelphia Polyclinic, etc. P. Blakiston, Son & Co., Philadelphia. \$2.00. 1891.



*A Practical Treatise on the Diseases of the Ear*; including a Sketch of Aural Anatomy and Physiology. Dedicated to Edward Talbot Ely, M. D. By D. B. ST. JOHN ROOSA, M. D., LL. D., Professor of Diseases of the Eye and Ear in the New York Post-Graduate Medical School and President of the Faculty, Surgeon to the Manhattan Eye and Ear Hospital, etc., etc. Wm. Wood & Co., New York. 1891.

*A Pocket Lexicon*; being a Dictionary of Words, Terms, and Symbols of Medical Science, collated from the best authorities, with the addition of new words not before introduced into a Lexicon. By D. B. ST. JOHN ROOSA, M. D., LL. D. Fourth revised and enlarged edition. New York. Wm. Wood & Co. Roan (red edges) 75 cents; Tucks (gilt edges) \$1.00.

We take pleasure in recommending this Lexicon to our readers. It is small enough for the vest pocket, yet it is printed in good plain type. It gives short definitions of familiar and unfamiliar old and new medical terms, with proper accents for guidance in pronunciation. Just the thing for the medical student who is paralyzed by the many-jointed names which roll so smoothly from the tongue of his teachers; just the thing for the reader of the medical journals who does not quite recollect whether *cholesteatoma* is a form of cancer or a cyst of the bile-duct, or whether *eczema* is pronounced with the accent on the first or on the second syllable.

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### Medical Progress.

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#### THE RELATION OF CHOREA TO RHEUMATISM AND OTHER DISEASES.

Dr. Sturges has an instructive article upon this subject in the *Amer. Jour. Med. Sci.*, Dec., 1891. He says:

My own personal testimony is to this effect: In 177 cases of chorea there are eight under six years old; *all but one are girls*. One of these must be omitted owing to defective information. Of the seven only three were certainly exempt from rheumatism. Three certainly, and a fourth probably, were rheumatic. Add to this the only examples procurable, so far as I know, below the age of four, the two I have just quoted, both showing chorea and rheumatism intimately associated, and the conclusion is not to be resisted that the rheumatic element is conspicuous in the chorea of very young children, almost all of them being girls.

Now, if chorea be considered without reference to age, this close connection with rheumatism is less apparent. It is seen chiefly, as I have said, at that early period of existence when the two affections are first discernible. As the time of life approaches when chorea becomes rare, while rheumatism—the acute polyarthritis rheumatica of young men and young women—attains its fullest development, this near connection is rarely seen. That the interval which separates these two affections should thus go on widening with growth, so that in the end sometimes rheumatism, sometimes chorea, emerges (not to speak of forms of neurotic arthritis, of which we know little), is not wonderful when we consider that each of these affections has its own separate exciting cause, and that each, once excited, is very apt to recur. The accidents of life will favor one rather than the other—exposure tending to rheumatic arthritis in one case, mental strain to chorea in another. In early life, when the affinity is the strongest, and before these separating causes have come into operation, rheumatism and chorea may alternate. But chorea tends to die out with puberty,

while rheumatism waits for puberty for its fullest development. Every repetition of the latter affection strengthens its hold and enlarges its clinical features—the rheumatism of seventeen being more express and distinct than that of seven. Meanwhile the natural disposition to chorea is weakening, and the time of life approaches when it ceases altogether.

The several points I desire to affirm are these:

1. Recent endocarditis, with no further heart change, is the cardinal anatomical feature in those dying with chorea without reference to rheumatism. Yet it is not constantly found, and some of the most striking examples of death by chorea are without it.

2. Choreic endocarditis is distinguishable from rheumatic endocarditis both clinically and anatomically. Clinically it is without physical or general signs, often without rheumatism, and only disclosed post-mortem. Anatomically the inflammation is recent, its chief, often its only seat, is the mitral valve, and there are no consecutive changes in the heart. The contrast to this condition is seen in rheumatic children with valve disease who are or who have been choreic. In them the physical signs observed during life correspond with well-recognized changes in the valves and heart chambers found after death and due to the rheumatism and not to the chorea.

3. Choreic endocarditis, therefore, is not accurately described as a manifestation of rheumatism. Both chorea and rheumatism are liable to this inflammation, each after its own manner. The common feature may be taken as evidence that the two affections are pathologically allied, not that either of them is a form or expression of the other.

4. The fact of this alliance is best seen by the observation of chorea in very early life, at which period it is often intimately associated with rheumatic polyarthritis in the same subject and at the same time. But with growth, in obedience to the natural history of the two affections respectively, and influenced by the several accidents of life, this association is relaxed, and at puberty it has ceased to be intimate.

5. Both chorea and rheumatism are, it is probable, members of a pathological group which has arthritis for a common factor, and of whose underlying source we are yet in search.

#### SWEET OIL FOR GALL-STONES.

In the *Medical and Surgical Reporter*, November 28, 1891, Dr. Mays presents the report of a committee appointed by the Philadelphia Polyclinic Medical Society to learn the views and experiences of the profession in regard to the value of this remedy. With this end in view a number of circulars of inquiry were sent out by the committee.

To these circulars nineteen replies were received, containing reports of thirty-seven cases of gall-stone colic treated with olive oil. Additionally the committee imposed the task upon itself to collect as far as possible all the previously reported cases of biliary colic which were treated according to this method; and succeeded in gathering records of seventeen cases, making altogether a list of fifty-four cases.

An analysis of these fifty-four cases shows that there were about one-third more females than males who suffered from gall-stone colic; that two died, that in three, negative results were obtained, and that in fifty, or in 98 per cent., positive relief was afforded. These results make a better showing still, when we consider that one of those who died was suffering from adhesive obstruction of

the bile-ducts—a disease which no procedure, either medical or surgical, could have remedied. Nor do these figures give us a true estimate of the favorable action of olive oil in this disease; for two of the observers state that they have treated forty other cases of biliary colic without a failure, but of which they had kept no record—making in all a collective return of eighty-nine cases—showing the great value of this drug.

These cases illustrate, then, the positive efficaciousness of sweet oil in the treatment of gall-stone colic, and the question naturally arises, therefore, as to the manner in which this agent acts. Dr. Rosenberg's experiments ("Ueber die Anwendung des Olivenöles bei der Behandlung der Gallensteinkrankheit," *Therapeutische Monatshefte*, December, 1889, S. 542), demonstrate beyond a doubt that it largely increases the quantity of bile secreted, while at the same time it diminishes its consistency.

But how does it accomplish this? Does it stimulate the biliary channels by coming in contact with their openings into the alimentary canal? Or it is decomposed into fatty acids and glycerine through the instrumentality of the pancreatic juice, and does the "glycerine so liberated exert in the duodenum an action similar to that which takes place when it is introduced into the rectum," causing a powerful reflex peristaltis—an ingenious theory suggested by Dr. D. D. Stewart? Or does it act in accordance with the hypothesis formulated by Virchow, who shows from his own experiments (*Therapeutische Monatshefte*, S. 86), that it is absorbed from the alimentary canal, is excreted by the liver, and is thrown into the bowels again through the biliary passages? The last of these theories appears to be most rational, because it explains certain well-known features in its action, and also places it on a level with the action of other cholagogues. We may conceive then that the beneficial influence of oil consists not so much in dissolving the biliary concretions, as it does in increasing the biliary excretion, in flushing, and in lubricating and washing out the passages of the liver. (A table of the cases was here reported.)

Another point of interest is the proper dose of the oil. Are large doses necessary? It appears not, for eight of the cases received only dessert-spoonful doses every three or four hours, and apparently with the same prompt and positive relief as that which was afforded by doses of from five ounces to one and two pints. If this should be confirmed by further experience it would be a great practical gain in view of the fact that a great many persons show a strong aversion to all kinds of oil, especially if they are to be taken in large quantities.

Furthermore, according to the observation of Dr. Stewart, it does not appear to make any difference whether olive or cotton-seed oil is used. Indeed, it is well known that much of the oil which is sold as olive oil is in reality refined cotton-seed oil; and Dr. Stewart's observation tends to show that in all probability any bland oil will have the same effect on the disease under consideration.

#### MEDICAL TREATMENT OF CYSTITIS.

From the advance proofs of an excellent article upon this subject read at a recent session of the Philadelphia County Medical Society, by Dr. James Tyson, we extract the following statements:

The only class of remedies I have found of service in cystitis through their internal administration are the balsams. Of these, the balsam copaiba is practically unavailable, because not one stomach in a hundred will submit to its ingestion in sufficient doses or for long enough time to permit it to be of any use. On the other hand, I have found sandal-wood oil very useful, and it is about the only remedy of which I can say this for its direct effect upon the mucous membrane of

the bladder. It is also comparatively well borne by the stomach, and is best administered in capsules containing ten minims. I believe it has heretofore been the usual custom to give these and like remedies after meals, but I have recently adopted the method of giving them on an empty stomach before meals. I believe they are as well, and even better, borne than when given after food, and they pass into the blood much more quickly. It is desirable to impregnate the blood and impart to the urine a balsam odor. This is scarcely possible with less than eight capsules a day—two before each meal and two at bedtime. I think I may say that I have found the so-called santal-midy capsules, which are, I believe, nothing but a very pure sandal-wood oil, better borne than the other specimens of the oil. I have given as many as twelve of these a day for considerable periods of time without deranging the stomach.

Bothboric acid and benzoic acid are useful adjuvants to the treatment of chronic cystitis through their antiseptic effect on the urine, each in 5 grain doses rapidly increased to 10. I have used resorcin in 5 to 10 grain doses, and naphthaline in 2 grain doses for the same purpose.

All who have had much experience with cystitis are familiar with the tenacious, glairy mucoid matter, which will not drop or rise up in a pipette, glistening with large crystals of triple phosphate, and exhaling a stinking ammoniacal odor which quickly contaminates an entire apartment. There is only one way to get rid of this, and that is to wash out the bladder, and too often this is too long deferred. Tepid water should be first used, and the injection made through the soft catheter now so invariably adopted. Sir Henry Thompson is very emphatic in his directions that no more than two ounces should be thrown in at a time, and that this should be allowed to run out, a like quantity again injected and allowed to run out, and this repeated until the water comes out as clear as it enters. In a very large experience in washing out bladders, I have never met an instance in which the amount named by Sir Henry may not be doubled with advantage, so that I begin with four ounces. When this quantity is used, a much shorter time is necessary to cleanse the bladder thoroughly; and after the capacity of the bladder has been determined I often throw in more, because it is sometimes useful to distend the viscus a little, for in this manner the depressions and inequalities between the muscular trabeculæ, always present in advanced bladder inflammations, are thoroughly reached. These simple injections, practised once a day, or in severe cases twice a day, often result most happily. I have seen the pus reduced from large bulk to a mere trace, and micturition reduced from five or six times to once a night. Commonly, after a few injections with plain water, I add some medication. My favorite is the salicylate of sodium in the proportion of a drachm to the pint. Its disinfecting qualities are undoubted, and I have some reason to believe that the soothing effect claimed for it is not without foundation. I have used a good deal of Sir Henry Thompson's soothing solution—of biborate of sodium an ounce, glycerin two ounces, water two ounces, and of this mixture half an ounce to four ounces of tepid water—with about the same result. Boric acid, in the proportion of a drachm to the pint, is also very satisfactory.

Alum is an astringent which has been too much overlooked of late in suppurating processes in mucous membranes, and may be substituted for the salicylate with advantage where the pus does not diminish as rapidly as is desired. It should be more cautiously used than the salicylate of sodium. Sufficient of the powdered alum should be first added to a pint to give it a distinctly astringent taste, when the bladder should be washed out as described, while a small quantity may be allowed to remain after the last injection.

Where there is a foul odor present I use the bichloride of mercury in solution, but exceedingly dilute. It is almost incredible how small a proportion of this salt is irritating to the bladder, and having learned by experience, I never begin with a solution stronger than 1:25,000, but gradually increase the strength if it is well borne. Carbolic acid may be substituted for the bichloride of mercury, but it has not been so satisfactory in my hands.

Anodynes are sometimes necessary to relieve the pain—as opiate in suppository. Cocaine in injections (2 ounces of 2 per cent. solution) has failed in his hands as an anodyne.

Catheterization and irrigation are needed in enlarged prostate with decomposition of urine.

#### LEUCODERMA SYPHILITICUM.

In an article quoted by the *Jour. Cutan. Disease*, Dr. Fifeisky, of Moscow, makes the following statements concerning this interesting condition:

1. Leucoderma syphiliticum or "primary pigmentary syphilide," constitutes a very common cutaneous manifestation during the condylomatous stage of syphilis. Most frequently it is localized on the lateral and posterior surfaces of the neck, but sometimes, besides those classical regions, it may also affect the lateral aspects of the chest, the epigastric region, and, though exceedingly rare, the thighs. It never attacks either the hairy scalp, or face, the inner surface of the mamma, the buttocks, forearms, hands, legs or feet.

2. There exist three distinct varieties of the exanthem, which may be termed *leucoderma marmoraceum*, *l. maculosum* and *l. retiforme* ("lace-like form").

3. In 40 per cent. of cases the rash makes its appearance during the third month after the first syphilitic symptoms (concerning which point—as well as some others—Dr. Fifeisky differs from Dr. Ehrmann: *vide* the *British Journal of Dermatology*, August, 1889, p. 346); in 20 per cent., during the fourth; in 20 per cent. during the fifth; and in the remaining 20 per cent. in the course of the second half of the first year.

4. Occasionally it may be observed simultaneously with gummatous manifestations.

5. In women, leucoderma occurs more frequently than in men; thus, it is observed in from 45 to 49 per cent. of all female condylomatous cases, and only in 28 per cent. of male ones. (Professor Fournier found the rash in 50 per cent. of female patients, and in 35 per cent. of male.)

6. In some cases the exanthem proves to be limited to a certain isolated area, while in others it may occupy a more or less extensive cutaneous territory.

7. In men, the extensive form is met with nearly thrice as frequently as in women; it is observed in about 50 per cent. of all male cases of leucoderma, and only in 18 per cent. of female cases.

8. The disease commences with an increased pigmentation of the skin (usually of the neck). After a while there appear minute circular or oval white patches or islets, which gradually increase in size to attain about that of a sixpenny piece. Subsequently the lesions become stationary, to persist for a more or less prolonged period, after which the white spots gradually grow less pronounced, and ultimately disappear without leaving any mark.

9. The duration of the rash varies from one to seven years. Most frequently it lasts three or four years.

10. In the case of a relatively late development, the manifestations of leucoderma are usually mild.

11. An intense rash of this kind, as a rule, develops in such patients as either

have not undergone any mercurial treatment about the beginning of syphilis, or in whom the specific treatment has been irregular or defective. In those who have been subjected to an early and regular mercurial treatment, the cutaneous affection commonly assumes a mild form. Neither mercury, however, nor iodide of potassium produces any apparent impression on the course or duration of the exanthem itself.

12. Leucoderma constitutes one of the most characteristic and most reliable diagnostic signs of condylomatous syphilis.

### Medical Items.

Mr. Hutchinson thinks there is not the slightest doubt that a patient who has suffered from syphilitic stomatitis, or, for the matter of that, from mercurial stomatitis is, if he persists in the habit of smoking, much more likely than other men to develop chronic sores, which may in the end pass into cancer.

Dr. R. L. Beall, a leading North Carolina physician, died at his home, in Lerion, Saturday last, of pneumonia. He was sixty years old and had held a number of important offices. At different times he represented his district in both branches of the Legislature and was trustee and director of several institutions of learning.

During a trial at Bremen of a dealer accused of having sold artificial "cognac" under this name, our present information regarding French cognac has been, if not materially increased, at least amply confirmed—viz., that there is scarcely any French cognac in the market that is derived purely from wine or grapes, and that there is none at all that has not gone through some process of dilution or improvement.

A meeting of delegates from the medical colleges of the State of Ohio was called Thursday, December 3, at the Neil House, Columbus, O., to co-operate with the medical societies and the physicians of the State in general in originating and securing the passage of suitable legislation regulating the practice of medicine in the State during the approaching session of the Legislature. One delegate from each college constituted the meeting, or convention. The purpose is to secure united action of the colleges in deciding upon the general principles of the legislation to be asked, before special bills are prepared or introduced.

The twenty-second annual meeting of the Medical Society of Virginia, held at Lynchburg, October 6th, 7th, and 8th, was characterized by much good work, completed and projected, of interest to the whole profession of the State. Among other resolutions adopted, was an important one offered by Dr. George E. Wiley, of Abingdon, Va., which provides for the appointment of a committee to petition the Legislature of Virginia to enact a law allowing the sum of not less than \$25 to every regular practitioner of medicine who may be summoned to testify as an expert before any court in this State. This is a subject of vital interest to every member of the profession in the State, since under existing laws physicians are liable to be summoned any distance and receive only the pitiful sum of *fifty cents a day*.

#### BACK NUMBERS OF JOURNAL WANTED.

Any one sending any of the following numbers of the JOURNAL in good condition, will be paid ten cents per copy: Nov. 29, 1890, No. 5; Dec. 20, 1890, No. 8; Dec. 27, 1890, No. 9; Jan. 17, 1891, No. 12; Jan. 31, 1891, No. 14; Feb. 14, 1891, No. 16; Feb. 21, 1891, No. 17; Mar. 14, 1891, No. 20; all of them of Vol. XIV. May, 16, 1891, No. 3, Vol. XV.

# MARYLAND MEDICAL JOURNAL.

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NO. 559

## CONTENTS

### ORIGINAL ARTICLES.

Notes on the History of Medicine. By Sheldon Guthrie Evans, M. D. (U. S. N.) . . . . . 133

The Rationale and Technique of Supra-Pubic Cystotomy. By Joseph Hoffman, M. D. Philadelphia, . . . . . 137

### SOCIETY REPORTS.

Medical and Surgical Society of Baltimore. Stated Meeting held Thursday, Oct. 8th, 1891. 140

### EDITORIAL.

City Parks for Children. . . . . 142

Therapeutic Testing. . . . . 143  
The History of Medicine. . . . . 145

### MEDICAL PROGRESS.

Powdered Nutmeg for Strangury.—The Habit of Case-Reporting.—The Graduation Oath of the Medical Department, University of California. —Potassium Nitrate.—A Questionable Sanitary Improvement.—A New Treatment for Fracture.—Dr. Finlay's Mosquito Inoculations.—Decay of Teeth in Young Mothers.—Treatment of Hip-Joint Disease —Examination of Drugs in Massachusetts.—For Accidents During Anæsthesia.—New Remedies.—Wound Infection. 146

MEDICAL ITEMS. . . . . 154

## Original Articles.

### NOTES ON THE HISTORY OF MEDICINE.

BY SHELDON GUTHRIE EVANS, M. D. (U. S. N.)

Whilst the study of medicine has been pursued with ardor, the study of its history and advancement to its present high state has, apparently, not received that attention which its importance demands. Such names as Hippocrates, Galen and Harvey are familiar to all, yet comparatively few know aught of their lives or their theories; and many physicians are unfamiliar with others whose lives and works have had great influence upon the progress of medical science.

This fact has led me to compile a few notes from various sources, and to present, in as concise a form as possible, the principal events in the history of this great branch of human knowledge.

The early history of medicine is involved in darkness, and it is, perhaps, useless to undertake to say how much truth there is in the legends of Greece concerning Chiron and his student Æsculapius. We know, however, that the temples of Æsculapius were visited by invalids at a very early period, and there they submitted themselves to the regulations of the priests of the temples. In the schools of philosophy also, some attention was always paid to the study of the healing art.

When the schools of the famous Greek philosopher, Pythagoras, were broken up, some of his disciples applied themselves to the practice of medicine and even visited the sick at their homes. The gymnasiarchs also contributed to the pro-

gress of medicine at this period, for they set fractures and acquired much skill in surgical operations.

- Thus we observe that medicine had made some progress when the "Father of Medicine," Hippocrates, appeared on the scene; collected the scattered knowledge on the subject, and, by his own genius, added much thereto.

Hippocrates was born on the island of Cos, in the year 460 B. C., and died in Thessaly. He studied medicine under his father, who belonged to the Guild of Asclepiadae, or priest physicians; subsequently, he went to Athens, and there he continued his studies under Herodicus. He practiced in Cos, Thessaly, Macedonia and Scythia, and finally returned to Thessaly, where he passed the remainder of his days. He it was who raised medicine to the dignity of a learned profession. His notions of anatomy and physiology were crude, because the religious prejudices of his time prevented dissection of the human body. In his opinion the use of muscles was only to cover the bones. The body was composed of four elements and derived from these were the four humors of the body: blood, phlegm, bile and black bile; and from these were further derived the four temperaments. Disease, according to his doctrine, consisted only in a disordered condition of the fluids. He speaks of a principle which he termed "natura," which influences every part of the body; the great aim of the physician was to watch the operation of this principle. The great merit of Hippocrates, however, lies in his descriptions of disease, and the accuracy of his observations.

Praxagoras, of Cos, the last of the Asclepiadae whose name is mentioned in the history of medicine, was the first to observe the relationship existing between the pulse and the general condition of the system. None of his writings, however, have been preserved.

The great philosopher, Aristotle, practiced medicine in his early life, and laid the foundation for the study of comparative anatomy. He distinguished the nutritive, sensitive, motive and intellectual faculties, and he also mentioned the ventricles of the brain.

Alexandria, rising into importance under the Ptolemies, quickly became the centre of medical knowledge. The library, the new drugs which commerce introduced from other lands, and, above all, the legalization of human dissection, gave a great impulse to medical science. Herophilus and Erasistratus were, by far, the most distinguished of the earlier members of the Alexandrian school. Erasistratus is said to have invented the catheter; and Ammonius, another member of the same school, invented an instrument for crushing stones in the bladder.

For five hundred years after the time of Herophilus and Erasistratus the study of anatomy appears to have been neglected; not until Galen appeared was it revived. Prior to the rise of the Alexandrian school, dogmatism, fortified by the authority of Hippocrates, was the prevailing system; but Philinus, of Cos, and Serapion, of Alexandria, arose in opposition and soon founded a new system, known as Empiricism, the main feature of which was the assertion that the only safe guides in medical practice were the effects of remedies in the treatment.

About one hundred and fifty years after this period of dogmatism and empiricism, Asclepiades, of Bithynia, began to practice medicine at Rome. He promulgated a new medical doctrine, according to which the body was permeated in all directions by pores, through which atoms, varying in form and volume, were constantly passing. Disease was an obstruction in the pores, or an irregularity in the distribution of the atoms. He was the first to separate diseases into two great classes of acute and chronic. The dogmatists claimed that the fluids were the prime seat of disease; and the Methodists, as the followers of Asclepiades and



his pupil Themison were called, taught that the solids were the first to be affected, and thus the dispute with regard to humoral pathology and solidism began, which has continued up to a very recent date; in fact, it may be said to be still in progress. Asclepiades was the friend of Cicero and Cæsar; on attaining supreme power, the latter decreed that all physicians at Rome should enjoy the privileges of citizenship.

After Asclepiades, the next noted man in medical circles at Rome was Soranus, a Greek, educated at Alexandria; his writings have perished unless, perhaps, as many think, the writings of Cœlius Aurelianus are a translation of them. The chief of the Latin medical authors was Celsus, who lived in the first century A. D., and wrote treatises on architecture, rhetoric, philosophy and medicine. His work, "*De Medicina*," is a digest of the medical knowledge of his time. In it he treats of the operations for stone and hernia; of wounds of the intestines and of cataract; gives directions for the use of the catheter; and speaks of trephining in injuries of the brain and of the ligature of lacerated vessels.

Galen, born in Pergamus in the year 130, A. D., is, after Hippocrates, the greatest name in the history of medicine. For more than twelve centuries his authority reigned supreme. He adopted the Hippocratic theory of the four elements, the four humors and the four qualities. Besides the solids and fluids, he assumed a third principle, the spirits. These were of three kinds: the natural, derived from the venous blood; the vital, formed in the heart by the action of air on the natural spirits; and the animal, formed in the brain from the vital. His most valuable works are those on anatomy and physiology, and his commentaries on the works of Hippocrates. He appears, however, to have dissected animals only, but recommended students to visit Alexandria, where they could enjoy the privileges of human dissection. His works comprehend all that was known of anatomy until the rise of Vesalius in the 16th century, A. D.

Dioscorides, who lived in the early part of the second century A. D., for many years enjoyed equal honors with Galen. He left a work on *Materia Medica* which comprises all that was known to the ancients, and for fourteen hundred years it was the standard treatise on that subject. From the time of Galen, medicine began to participate in the general decline which had already overtaken art and literature. Under the Christian emperors every town of a certain size had its archiaters or chief physicians, and no one was allowed to practice without having undergone an examination; thus we see that it was only when medicine already tended toward decline that it became a legally organized profession. About this time medical schools were also established in the principal towns.

Hospitals and dispensaries owe their origin to Christianity. The first one was established at Cæsarea by Saint Basil about the close of the fourth century.

During the struggle for existence of the Eastern Empire, medical science sought refuge among the Arabians, but they did little to further its progress. The chief work of that period is the "*canon*" of Avicenna, which, for several centuries was a universal text-book.

In two particulars only were the writings of the Arabians of importance, namely: in their accounts of the eruptive fevers, and in the use of the milder purgatives. The introduction of the many new pharmaceutical preparations, including the metallic salts, together with the foregoing discoveries, laid the foundation of Pharmacy, a science of paramount importance to the medical profession and its advancement.

From the 9th to the 13th centuries, the Jews became the most noted physicians, acquiring much of their knowledge from contact with the Saracens of Arabia and Spain.

It may be well to state here that the title of Doctor was first employed in the 12th century at the time of the establishment of the older European universities. The first person upon whom it was conferred was Irnerius, a learned professor of law at the University of Bologna, who induced Emperor Lothair II, whose minister he was, to create the title, and who was made LL. D. by that university. Subsequently this title was borrowed by the faculty of theology, and it was first conferred by the University of Paris on Peter Lombard, the celebrated scholastic theologian. William Gordenie was the first person upon whom the title of Doctor of Medicine was bestowed, he having received it from the College of Asti in 1329.

The school of Salerno, in Italy, affords a ray of light during the darkness of the period just subsequent to the burning of the Alexandrian library, it having been founded about this period. From the 10th to the 13th centuries it was at the height of its celebrity, and the "*Regimen Sanitatis Salerni*," the dietetic precepts of this school composed by John of Milan, has been republished as late as 1872, translated by Prof. Ordonaux. The most noted member of this school was Constantinus Africanus. In the 13th century Frederick II published an edict that all physicians should undergo examination before the faculty of Salerno, failing in which they were not permitted to practice.

In 1315, Mondinus, a professor at Bologna, dissected two female subjects and published a description of his work. For three hundred years this book was used as a text-book in Italian schools.

In 1543, Vesalius, a professor of anatomy at Padua, published his great work on anatomy.

The first complete work on Surgery, by Guy de Chauliac, was published in 1363. Previous to this time surgical operations were generally performed by barber-surgeons, owing to the fact that most of the learned physicians were priests whom a canon in the church forbade to shed blood. Surgery, however, received its greatest impulse from Ambrose Paré who, in 1536, abolished the practice, then prevalent, of pouring boiling oil into gun-shot wounds.

In the 15th century we first hear of a number of new diseases, such as scurvy, whooping cough, syphilis, etc., and much of this may be attributed to Paracelsus, who openly attacked the opinions of Galen and Avicenna. The anatomists of the 16th century had paved the way to the discovery of the circulation of the blood; such men as Cæsalpinus and Servetus having had considerable knowledge on points such as the lesser circulation through the lungs, the cardiac valves, aorta, etc., but it remained for William Harvey, an English physician, to take the last great step. After having taught the circulation for ten years in lectures, he, in 1628, published his theory to the world in a work entitled, "*Exercitatio anatomica de motu cordis et sanguinis in animalibus*." Harvey was born in Folkestone, April, 1578, and died in London, June, 1657. He received his degree of A. B. at Cambridge and in 1602 was graduated as Doctor of Medicine at the University of Padua. He expresses himself as indebted to his preceptor, Fabricius, for his discovery, but, beyond the discovery of the valves of the veins by Fabricius, the merit undoubtedly belongs to Harvey. He also received the degree of M. D. from Merton College, Oxford, of which institution he was warden. In 1652 his statue was placed in the college hall of the College of Physicians. I have omitted to mention many whose works have had considerable influence upon the advancement of medical science, such as Trotula, Gariopontus and Copho, of the 9th century; Gorrivani, Gunther, Linacre, Brissot and others, of the 15th; Lancisi, of the 18th, and others; but I hope a sufficient

number have been mentioned to give the student a slight knowledge of this too much neglected subject.

It may be well to close with a brief sketch of the foundation of the Homœopathic system of medicine by Samuel Christian Friedrich Hahnemann, who was born in Saxony in 1755, and died in Paris, July, 1843. He studied medicine at Leipsic, devoting his leisure to teaching languages and translating medical works into German. In 1779 he received his degree of M. D. at Erlangen. In 1790, while translating Cullen's *Materia Medica*, he was struck by certain contradictory properties ascribed to Peruvian bark; he experimented upon himself with this remedy and, after a large dose, discovered symptoms similar to those of intermittent fever. This appears to have suggested to his mind the law which he subsequently announced as the foundation of his system—“*Similia similibus curantur.*” This doctrine soon spread and, in 1825, was introduced into the United States by Hans B. Gram, of Boston, a physician who was educated at Copenhagen. The spread of this system, however modified, in the United States has been somewhat surprising.

#### THE RATIONALE AND TECHNIQUE OF SUPRA-PUBIC CYSTOTOMY.†

BY JOSEPH HOFFMAN, M. D.

The history of this now classical operation for all the affections of the bladder where surgical interference is justifiable is a travesty upon the acumen of the surgeon. I speak widely, and it may seem to some, unwisely, but it appears to me such expression is only moderate when all facts in reference to the subject are considered. The lateral operation for stone, as is well known, became popular because of its success upon children. Hence the reasoning by which it was indiscriminately applied to all cases in the adult seems only ridiculous when the same methods of arguing the so-called high operation out of the sight are scanned. The high operation was dangerous because of wounding the peritoneum, and this was gravely held to, after it was well-known that the operation had been performed at any early day with success and that the anatomy of the parts is such that the peritoneum is easily escaped. Up to within a decade the same logic is followed, and the supra-pubic operation is gravely dismissed with the feeble criticism that the statistics of the operation are not good, though such condemnation is followed generally with the explanation that this is perhaps due to the fact that the operation has been reserved for cases in which other operations could not be done, and accordingly the patients were in an unfavorable condition. It is not the intention of this paper to go into the history of the operation, only as to show that the reasoning against it, both present and past, is in the highest degree unworthy of acceptance, and in fact does not amount to reasoning at all. It is intended rather to call attention to the fact that in the opinion of the advanced surgical exponents of to-day it is the operation, besides which all others, in the treatment of vesical disease, must play an unimportant part. Here in Philadelphia we have had much urgent opposition to the acceptance of this fact, but also it is pleasant to know, that here also there has been a much and well-argued stand taken for the operation. In this connection Dr. Dulles must have unstinted credit.

It is too much the fashion in surgery, as in physic, to follow out an ancient idea as if it were inspired. The mummies of science are no more worthy of ador-

†Read before the Philadelphia County Medical Society, November 11th, 1891.

ation than error in any other form. So-called scientific data which are not and never were scientific, are at the bottom of much mischief and many disasters in practical surgery as well as in physic. The arguments by which the supra-pubic cystotomy can be urged for general acceptance in all cases in which it is proposed to enter the bladder, are all based upon anatomical fact and practical results in good hands. Those who are having the most experience with it are giving it the highest praise. Looking at the now generally accepted axioms of this latter-day surgery it is difficult to understand how this can be otherwise. In the perineal point of attack by which the bladder is to be entered there are many structures of vital importance and whose anatomical distribution are far from uniform. On the other hand, in the supra-pubic operation, there are no important structures to be met; there are no blood-vessels that cannot be easily controlled in the sight of the operator; there are no anomalies to be expected, and if they do occur, need have no terror for the operator. The operation then being always under the complete control of the operator, is clearly the one to be preferred from a merely theoretical standpoint. But theory does not always hold good in practice, so let us see whether here we are also misled. The dangers most to be dreaded from the perineal operations are hæmorrhages and contusion of the parts by the passage of a large stone, especially injury to the seminal vesicles. In the procedure under consideration we have seen there is no danger from hæmorrhage, and the contusion cannot interfere with vital structures because they are not met; the bladder is not wounded where its integrity is interfered with, and even if a stone larger than is suspected is to be dealt with, there is no difficulty in removing it far more successfully and certainly and simply than by any other method. I do not except the now generally accepted method of crushing. The reasoning by which this conclusion is reached I think so clear that I will not follow it out. How many of the older operators in this Society, in this room, have in mind harrowing attempts to get control of calculi imbedded in the bladder, of hands introduced into the rectum, in order to bring the stone into the grasp of the forceps, of lacerated bladder, perineum, urethra, and all of which it is the hope of the operator to escape! It will be evident to the veriest tyro in anatomy that all this not only can be escaped, but is escaped, in the supra-pubic operation.

The next *bête noir* of the perineal operation is urinary infiltration. It cannot be questioned that in this latter operation the larger the stone the greater the danger of contusion and, therefore, the greater the danger of urinary infiltration. Now, in supra-pubic cystotomy, the danger of infiltration is practically *nil*, for the reason that there is no deep dissection of parts, that the urine passes gently upward and outward, and cannot lie collecting and dissecting by gravity into the adjacent structures. The danger of infiltration in the supra-pubic incision can only be said to obtain when an attempt is made to close the incision, and hence it has become an axiom in the operation that the incision is better left open. There is found to be but little danger of fistulæ—in fact, the great difficulty is to keep the bladder open as long as necessary. Accordingly we see that the three paramount dangers of the perineal operation are absent in the abdominal operation, and that theory and anatomical facts combine to demonstrate the legitimacy of the newly adopted operation. Now let us further consider some of the points in which it is asserted that the lateral operation for stone is superior. In children, for instance, where there is less danger of extensive laceration, it is claimed such is the case. Let us see. A year ago I said to Dr. Deaver: "I am going to do a supra-pubic cystotomy for stone." The question was: "What is your case?" The answer was: "A boy, three years old."

Again the answer: "You have a favorable case," and the opinion was justified by the result. It must be remembered that in children the bladder is rather an abdominal than a pelvic organ, and that lying higher it is more readily reached. In the case just referred to the recovery was absolutely uneventful. After the first day the child lay comfortably in bed, playing, with neither fever nor pain. In great contrast with this case comes the report in a volume of the *Transactions of the Southern Surgical Society* in which a vaginal cystotomy was done upon a child six years old. Imagine the consequences at their best—the laceration, the pain necessarily supervening; but take into consideration subsequent operation for vesico-vaginal fistula, and the too late concession of the operator, that had the size of the stone been suspected, the supra-pubic operation would have been selected. Herein lies the folly of choosing any operation instead of another which will answer all conditions, because in tradition no alternative has been preserved. I take it to be a surgical postulate that in every instance that operation should be selected which promises the greatest relief with the least danger or discomfort to the patient. It is not a question of what operation we are used to performing. It is which operation best covers the ground. The argument has, up to this point, been directed to cystotomy from the standpoint of operation for calculus. It is not limited to this, however. In the male we have prostatic disease, than which there is no greater bane to old age. Hitherto the only relief was by constant catheterization. Now it is a recognized procedure to drain the bladder permanently from above. No one needs further argument than the case reported by McGuire, of Richmond, and of the Davies, of Alabama, to be convinced that this operation to old men is the greatest possible boon. Not only is the bladder drained, but the prostatic enlargement is itself removed with the greatest success, and in many cases the disease permanently cured. Belfield, of Chicago, a year ago gave an exhaustive tabulation of this operation, and its success places it among the most important additions of the day. It now becomes evident that since drainage is a most important element in the treatment of chronic cystitis in women, a most desired step is attained, by which the woman with comfort and cleanliness is able to go about while she is being cured, with no discomfort, and cleanly. McGuire gives as his opinion that there is no difficulty of so managing the supra-pubic opening that the urine can be retained for six hours. This being the fact, there is no longer reason for drainage *per vaginam*. By this it will be seen that in all cases in which it is intended to open the bladder the supra-pubic operation gives most assurance of all-round success, whether in adults or children, whether the disease be simple inflammation or chronic prostatic enlargement. This is my experience, both in operations upon the child and adult. It is evident also that in cases of encysted calculus, the operation is absolutely sure of success.

The details of the operation are exceedingly simple. Much has been written that tends to produce an impression that the steps are more or less complicated. No special instructions are needed. A bistoury and a few artery clips are all that is required—additional instruments only being called for according to the conditions met after exploration. The injection and washing out of the bladder are, I believe, all that the surgical aspect of the operation requires.

The bladder can be easily reached both in the child and adult without packing the rectum. The relative size of the bladder in the adult and child is to be regarded, care being taken not to over-distend the viscus. The incision is made close down to the pubis, and two pairs of artery forceps used as retractors; as the incision is deepened, obviates all necessity for special instrument or additional

procedure. The supra-pelvic fat is pushed asunder with the finger, and the bladder comes into view or is easily felt at the bottom of the wound. The viscus is easily raised into the wound by the forceps applied again after the manner of using them to raise the peritoneum, and the incision is readily made. The forceps can still be retained in position or, if deemed expedient, a thread can be introduced by which control over the edges of the wound is maintained. The subsequent procedure is now dependent on the operation to be done. If drainage only is intended, a rubber tube is stitched into the wound or a hard drainage tube retained by simple means.

If a calculus is to be removed, the procedure is as simple as taking a cherry from its seed. The operations for tumor and prostatic disease are, of course, more extensive and dangerous, and these it is not the purpose of the paper to consider, but only to call attention to the fact that their removal by this operation becomes more a matter of surgery and less of experiment than by any other means whatsoever.

Finally, for the operation all can be claimed that simplicity, accuracy, and safety can commend. The so-called statistics of the operation before it was fairly tried, or used for other than forlorn cases, cannot be used either to condemn or recommend it. Its results, as obtained at the present time by exact surgeons, working thoroughly and entirely from an anatomical standpoint, give it a record unequalled by any other method of dealing with the surgical diseases of the bladder.

### Society Reports.

#### MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, OCT. 8, 1891.

The 729th regular meeting of the Society was called to order with Dr. R. W. Mansfield in the chair.

The minutes of the previous meeting were read and approved.

The following gentlemen were elected to membership: Dr. C. H. Wood, Dr. W. B. Burch and Dr. J. Percy Wade.

*Dr. Herbert Harlan* read a paper entitled SOME CASES OF OBSTINATE TINNITUS AURIUM TREATED BY PARACENTESIS. (See page 6). DISCUSSION.

*Dr. A. D. Mansfield:* I have treated two cases by paracentesis. One was partially benefited and the other was relieved of the tinnitus. I find tinnitus quite a bugbear to treat, but I think I can get relief in some cases by strychnia in  $\frac{1}{16}$  to  $\frac{1}{8}$  grain doses, three times daily.

*Dr. Harlan:* I did not mention any remedies in my paper, as I was discussing paracentesis only, but as Dr. Mansfield has mentioned strychnia, I recall a case that was relieved by five grain doses of quinine, four times daily. She gets entire relief by taking two grains of quinine, three times daily, whenever the tinnitus returns.

*Dr. F. C. Bressler* read a paper entitled REPORT OF A CASE OF CHRONIC SUPPURATIVE OSTEO-MYELITIS OF FEMUR, WITH AMPUTATION. (See page 94). DISCUSSION.

*Dr. R. G. Davis:* These cases are often the result of small injuries and if not treated right in the beginning, they may cause an endless amount of trouble. I saw a case at the City Hospital some time ago, a man 60 years old, who had been seen by Pancoast, of Philadelphia, who had refused to operate on him. Dr. Chambers operated by cutting down and scraping the bone. When the patient was carried from the table he was in a very bad condition. He recovered, how-

ever, without any trouble at all, which shows that even where cases appear hopeless, they may recover if operated on.

*Dr. A. D. Mansfield* read a paper entitled THE PRESENT STATUS OF THE HYDROCHLORATE OF COCAINE AS A LOCAL ANÆSTHETIC. (See page 551, Vol. XXV.)  
DISCUSSION.

*Dr. E. W. Willis:* I endorse all that Dr. Mansfield has said of cocaine in eye surgery, but I do not think its greatest field of usefulness is there. In an experience of a year and a half in minor surgery in the out-patient department at the Johns Hopkins Hospital, I think we find cocaine quite as efficacious as it is in eye surgery. We see from four to eight cases a day and in 50 per cent. of the cases it proved efficacious. We use a one or two per cent. solution and have even used distilled water. In using a solution as weak as this, we do not find it necessary to take the precaution against its absorption by ligating the parts. In incising the edges of chronic ulcers we use a ten per cent. solution on cotton, allowing it to remain on ten or fifteen minutes, and we find anæsthesia was efficacious in far more than 50 per cent. of these cases. I repeat that I think the use of cocaine is quite as efficacious in minor surgery as it is in eye surgery, and it is certainly capable of a wider and more general application, as we all of us do more or less minor surgery, while only a comparatively few of us do eye surgery.

*Dr. S. T. Earle:* I endorse what Dr. Willis has said, but I wish to state that cocaine can be used in more important operations. I use it in all rectal operations. In simple fissure, in fistulæ and in clamp operation for hæmorrhoids. I use a stronger solution than is used at the Hopkins hospital. I use one grain to fifteen minims and try to use less than two grains in any one operation. I have not had any bad effects of late, as the solutions are weaker than I used formerly I inject each hæmorrhoid just before operating on it. By this method the operation is prolonged a little, but it reduces the liability to absorption.

*Dr. W. H. Norris:* I have used a two per cent. solution on the urethra in passing the catheter and have found it to work very satisfactorily. I use it in extracting teeth at the dispensary with equally good results. I have heard a good deal said about its toxic effects, but have not had any such experience myself.

1710 W. Fayette St.

J. WM. FUNCK, M. D., Sec'y.

#### HOW TO CARRY TINCTURE OF IODINE IN YOUR SACHEL.

This is a subject of interest to every one who has been so unwise as to put a bottle of this useful remedy into his satchel. The advice given by Dr. Abbott in the *Medical Record* will, therefore, be welcome.

He says: Every gynæcologist is well aware of how many bad words he is responsible for when the cork of his iodine bottle becomes extracted in his instrument case, destroying his satchel and rusting his fine instruments, or when it upsets on his patients' carpets, leaving its indelible stain as his unfortunate autograph. After trying all sorts of bottles and stoppers, I have found the following avoids all these annoying accidents: Fill the bottle selected with absorbent cotton; pour in the tincture iodine to complete saturation; then pour out all that will readily drain away. One now has plenty of iodine in a very safe form. Any application thrust into the cotton-filled bottle will be immediately saturated, for painting the vagina, or external work. Yet the bottle may be carried safely in satchel, or upset on the carpet, etc. I hope this method for a "new iodine bottle" may save the instruments of others, and be of as much convenience and saving to them as it has been to me. This plan may also be adapted to other medicines, as pyroligneous acid, carbolic acid, or any other material used for applications and liable to spill.

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BALTIMORE, DECEMBER 12, 1891.

**Editorial.****CITY PARKS FOR CHILDREN.**

One of the most remarkable and at the same time encouraging tendencies of nineteenth-century life, is the thought which is bestowed in promoting the happiness and the health of the children. The money and ingenuity and talent which is expended now-a-days in the production of books for children is most astonishing to one who has been brought up according to old-fashioned methods and among old-fashioned books.

The problem of furnishing out-door recreation, of a healthful and yet not demoralizing nature, for the children of our great cities, is one which demands the attention not only of the philanthropist, but also of the statesman. For, with the increase in growth of cities, the children of the poor—and perhaps to a still greater extent, of the middle-classes who do not consider it proper to let their children run wild in the streets and play in the gutters—are cut off more and more from healthful means of recreation, and are prematurely developed into delicate or sickly young men and young women and driven for entertainment to questionable forms of amusement. Any city-bred man who reflects upon the subject will become aware that the boys are driven further and further away from their homes into the suburbs in search of play-grounds for base ball, etc.; being no longer permitted to play upon vacant lots or in unfrequented streets of the city as was his custom in boyhood, and indeed vacant lots are now few and far between in the localities where once they were numerous. Baltimore has, in consequence of its wide extent in proportion to its population and the absence of great tenement-houses, up to this date escaped the evils which have threatened the health and moral purity of such great centres of population as New York. Yet it is time that our public spirited citizens should take measures to guard even this favored city against evils which will otherwise surely



come upon us and which can be much more easily prevented than remedied. We must look to the innate selfishness of the human heart if we would find the motives which have led men in the race for wealth and magnificence to wrest from the children their natural play-grounds and forbid their games upon the streets without providing squares and parks where they can play without disturbance. But have we not ornamented our cities with many beautiful public parks? Certainly. But a mere glance will show that these parks are laid out by persons who have either forgotten what childhood is or have never intended to provide play-grounds for the children. Five years ago New York had "several thousands of acres of parks for adults and for children on dress parade, and not one spot belonging to the children." And what a hot-bed of juvenile disease and vice has it become.

It is therefore with great pleasure that we learn from the "open letter" columns of the *Christmas Century* that a very strong movement has been set on foot in New York looking to the fitting up of small lots here and there throughout the city as play-grounds for the children. The lots are surrounded by a high board fence and are furnished under due supervision with swings, wheelbarrows, shovels, toy-wagons and see-saws for small children, and with race grounds, ball grounds, etc., for the older boys. The diversion found most popular is that of parades with drums and flags.

The New York Society engaged in this work proposes to furnish eventually, close by their homes, for all boys and girls, at public expense, the play-grounds which they need and which not even wealthy parents now provide for their children; holding that the physical welfare of the children means the happiness of future humanity and deserves one thought even in the rush and the whirl of modern business life.

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#### THERAPEUTIC TESTING.

Certain knowledge of the therapeutic properties of a new drug can only be obtained by its administration to patients; but there are many ways in which its virtues may be inferred.

First—If it is an extract from some known plant, it is proper to suppose that it will possess some of the properties of drugs extracted from other plants of the same family.

Second—If it is a synthetic compound, formed by the introduction of a certain radicle (group of atoms), into a substance belonging to the carbon series, it may be expected to possess, in a more or less modified form, the properties of the radicle introduced. The recognition of this principle has led to the formation in the laboratory of some very valuable drugs; and still more valuable results may be expected to follow the extensive work which is now being done in this line.

Third—New drugs may be tested by administration to some member of the animal kingdom other than man. The animals thus experimented upon are generally in good health (we have never heard of any systematized effort to test drugs

for human use in a dispensary or hospital for sick animals). This method is extensively used by a certain class of therapeutic investigators. It is found that the conclusions formed from observations upon animals do not always hold true in the case of human patients; and, indeed, that different species of animals are affected very differently by the same drug. Dr. H. C. Wood, however, in his able treatise on therapeutics, holds that such variations are due to either known or discoverable differences in the weight, habits, diet or functions of said animals; and that in this way, alone, can the laws of therapeutic action ever be established.

Fourth—A knowledge of therapeutic virtues of drugs may be sought by administering them to healthy persons, and recording the symptoms which follow. The method has been in use by physicians probably since the earliest days of medicine. Practitioners of the homœopathic school have attempted to found upon it a new system of therapeutics.

The objection to this method is that it is applicable only in the case of drugs which powerfully influence the functions of the healthy body. If such drugs be given in sufficiently large doses, it is evident that the functional or other disturbances which follow will indicate, with some accuracy, the manner in which the drug acts and the organs which are affected by it. The dangers to the individual on whom the test is made is also to be considered, in such experiments, with new drugs. Many drugs are so feeble that their effects may be obscured by, or confounded with, accidental variations in the health or condition of the individual upon whom the test is made; and, moreover, when a physician experiments thus upon his or her own body, the drug symptoms may be confounded with functional changes resulting from the necessary mental introspection of the observer. As most of the therapeutic agents introduced by homœopaths are generally reputed to be either very mild or wholly inert, one may easily understand the fallacy of most of their "provings."

The objections to provings on healthy men and women holds with almost equal force in the case of the method just mentioned, where healthy animals are used. The only advantage in the latter instance is that we do not value highly the comfort and health of the animal; and kill it when the experiment is over, so as to study the tissue-changes produced by the drug.

Fifth—The practitioner has usually hitherto obtained indications as to the therapeutic use of each drug from a knowledge of the effects of that particular drug in similar disorders of the same patient or of other patients. This knowledge gained either in his own experience, or from the verbal or written statements of other observers, constitutes, with a certain skill in reading the indications of disease at the bedside, his chief claim to the dignity of physician. As all new drugs are carefully submitted to this test before they assume an acknowledged place in the materia medica, the therapeutic principles laid down by our fathers in regard to the drugs known to them still retain great authority.

For the thorough testing of the therapeutic virtues of a drug, every possible method of investigation must be employed. The therapist who gains his

knowledge exclusively from one method of drug-proving, will fail to elicit all the virtues of his agents, or will fall into serious error concerning them.

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### THE HISTORY OF MEDICINE.

The presentation of the brief article of Dr. Evans on this subject in another column of the present issue needs no apology. That elevation and ennoblement of the medical profession, which it is the duty and the privilege of the medical journal to promote, can never be reached so long as medical men devote *all* of their time and thought to the details of every-day practice. The physician should have some time for general reading, and should early acquaint himself with the history of his own profession.

Unfortunately, it is difficult to obtain short treatises upon the whole field of medical history or upon any particular portion of it. The perusal of encyclopaedia articles in this connection is not satisfactory and but few portable volumes in English upon the subject are to be found in the medical libraries. The quaint old work of Freind in two small volumes is one of the best, but not every library has a copy of it.

The history of medicine is not taught in the colleges, and it is to be feared that very many physicians of good standing are shamefully unfamiliar with the steps by which their art has emerged from the obscurity of ignorance and superstition and has developed into its present vast dimensions.

A short and entertaining sketch such as that offered by Dr. Evans will therefore be welcome to many of our readers, who will find it pleasant as they sit by the fireside after the day's rounds are done, to recount with the author the names and deeds of those venerable seekers after truth in the ages of long ago.

Nothing is more forcibly taught by the study of medical history than this fact: that the true secret of medical progress is the careful, humble and sincere study of the open book of nature. The stars which shine brightest in the firmament of medical history are the names of workers, who, casting aside the precepts of men fallible as themselves, and spurning the misty speculations of philosophy, have gone back to the first sources of revelation in medicine, scanning with their own eyes the tracery of anatomy, testing with unbiased mind each therapeutic agent, imitating in their surgical ventures the processes which Nature herself sometimes employs for the healing of diseases or the repair of injury.

The truest physician is he who, knowing what has been done in the past and familiar with the problems before him, labors in the spirit of these fathers of his art and jots down for the use of future generations the bits of truth which have been the reward of his patient toil.

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The subject selected by Dr. Hunter McGuire for his next prize of one hundred dollars for the best original essay prepared by any member of the State Medical Societies of Virginia, West Virginia or North Carolina is *Tetanus*. All type-written or printed manuscripts offered in competition must be in the hands of the Recording Secretary, Dr. Edwards, Richmond, Va., before August 15, 1898.

### Medical Progress.

#### POWDERED NUTMEG FOR STRANGURY.

In presenting a paper on the "Uses of Methylene Blue in Malaria" recently before the Clinical Society of Maryland, Dr. Thayer remarked that the strangury, vesical tenesmus and scalding from the urine, which occurred in most cases in which methylene blue was used, had been readily relieved in each case by the administration of from one-fifth to one-fourth of a teaspoonful of powdered nutmeg, three or four times a day.

He stated that the use of this drug for such strangury was first suggested by the experience of the peasants in Bavaria, where powdered nutmeg was a popular remedy for the dysuria which sometimes followed the excessive use of beer.

#### THE HABIT OF CASE-REPORTING.

From a suggestive address of Dr. Frank Billings before the Alumni Association of the Chicago Medical College (*Chicago Medical Recorder*, Nov., 1891) we clip the following paragraphs:

As I said before, it would be most fortunate if each could have a hospital experience, but without it one may be just as successful. The period of necessary waiting can be used in the reading that was not possible while in college. Every practitioner should have a microscope. The young doctor has no excuse for not possessing one, even if he be poor. Some sacrifice can be made which will secure one. With it he cannot spend too much time. Rich returns in the form of satisfactory knowledge and of money will repay one many fold. Besides books, he should formulate a system of case-taking; or if he cannot make a satisfactory one himself, copy from some one else. Every case, at least every case of importance, should be carefully written up. At first, plenty of time will be found for this, and when cases become so numerous that time is important, he will have acquired a way of keeping pace with them. Case-taking teaches more than the idler appreciates. Each patient is more carefully studied, more accurate diagnoses are made, and consequently the applied therapy is more rational. A quickly growing reputation among the laity for carefulness, accuracy and successful treatment, makes abundant returns for what at first seemed unnecessary and worthless labor. Then a case-book offers one constant material for reference study and also for reports to societies and to medical journals. Did it ever occur to you that have attended our local, State and national societies that most papers and reports were read by almost the same men year after year? Even the leading articles in our best medical journals are furnished by the same men year after year. By this I mean that most doctors do not read papers or reports of cases before our societies, nor do they write articles or reports for our papers. Why not? Because they are lazy. Idleness is a habit. Case-taking is the exception with most physicians; they have never done it and are too lazy to begin. Without a case-book there is no original matter for a report or a paper, and this habit of idleness is so cultivated that it would be a most difficult labor to write even a simple report. And yet there is more to be gained in money and reputation among physicians from one well-written paper or report than one can estimate. A well-written report of cases, or a good paper well supported by clinical facts, read before a society, or published in a good journal, will bring the writer more reputable notoriety than he would gain in ordinary hum-drum practice in a year. Such reputation is valuable, too, as it means the respect and confidence of your fellow practitioners; and let me say, the

friendship and confidence in your ability of one physician is of more worth than the friendship and confidence of ten laymen.

I have really pointed out only the selfish side of the subject. To write reports and papers, one must read. Journals will be searched and books over-hauled, and as a result an amount of reading is done which no other stimulation would have brought about. The beneficial effect of this is obvious.

No matter how busy the practitioner may be with his every-day practice and cases, if he be systematic and painstaking he will lay up material daily for future study and profit.

#### THE GRADUATION OATH OF THE MEDICAL DEPARTMENT, UNIVERSITY OF CALIFORNIA.

An editorial in the *Pacific Med. Jour.*, Nov., 1891, states that it is the custom in the above-named college to require the graduates to take the following oath:

Do you solemnly promise and swear in the presence of Almighty God and these witnesses, that in the practice of the profession to which you have been admitted, you will be actuated by philanthropy and guided by charity, and that you will recognize no superiority of the claims of the rich over the poor upon your attention; that you will strenuously avoid in every act the practice of charlatans and pretenders, and exert yourself to the utmost to the end of preserving the escutcheon of your profession untarnished. That under no pretence or pretext whatever will you aid or assist by counsel or otherwise any unlawful scheme or unworthy act, and that you will give your aid to bring all such to justice. That you will hold sacred and keep inviolable every secret confided to your trust in your professional capacities, and that you will not voluntarily communicate to any one information as to the nature of another's disease; that you will through unremitting labor and study contribute to the already accumulated facts in the science, such others as may fall under your observation, or result from investigation, and through your assiduity and industry you will do all in your power to enrich the science of your profession. And finally, that you will strictly observe and obey the ethics of the profession as laid down by the American Medical Association, and that upon the willful violation of these or either of these obligations, you hereby agree and consent to yield your diploma on demand, and have your name stricken from the Alumni of this college.

#### POTASSIUM NITRATE.

The *American Chemical Journal* states that until twenty years ago nearly all the saltpetre, or potassium nitrate, of commerce was obtained from India, where it is collected in the form of an incrustation upon the soil in thickly populated regions, arising from the gradual oxidation of animal organic matter. The supply of saltpetre from this source has decreased.

The deposits of sodium nitrate, or Chili saltpetre, near the sea coast of Chili, in the province of Tarapaca and the desert of Atacama, have lately been fully described in a most interesting report by Consul Walker, of Bogota. These deposits have been known and worked for nearly seventy years. They extend a distance of 260 miles along the coast, and have in some places a depth of over six feet. By far the larger part of the product is used in agriculture.

Potassium nitrate is now chiefly obtained by treating the Chili nitrate of soda with potassium chloride from Stassfurt. More than 50,000 tons of the nitrate of soda produced in 1888 was used for this purpose, and Pfeiffer states that 41.2 per cent. of the potassium chloride produced at Stassfurt is employed in this industry.

## A QUESTIONABLE SANITARY IMPROVEMENT.

According to the *Journal of the State Medical Society of Arkansas*, the inhabitants of the city of Little Rock have their troubles like other people. It announces that,

“The filtered water now furnished the citizens of Little Rock has one possible source of danger that it did not possess when it was so densely muddy—that is partial clearness. Its former muddy appearance was so repulsive that it answered the purpose of a danger signal. Now that it is nearly clear and potable in appearance, there is no telling what ills may result from its use. It was formerly muddy and *dangerous*; it is not now very *muddy*.”

We congratulate Arkansas on the possession of a very creditable journal and we hope that some liquid substance—not inebriating—will be found with which the natives of that western clime can safely slake their thirst.

## A NEW TREATMENT FOR FRACTURE.

The *Therapeutic Gazette* states that, recently, at the opening meeting of a British medical society, Dr. Mansell Moullin read an interesting paper on a new treatment for severe complicated fractures, which, in his hands, has yielded very excellent results. His practice is to immerse the limb in a trough filled with an antiseptic lotion, kept at the temperature of the body. He begins by using a lotion of corrosive sublimate, of the strength of 1 to 100 (?), reducing it in a day or two to 1 to 10,000. As a rule, the immersions were kept up for an hour twice daily, but some cases were treated by almost constant immersion. The limb, in the intervals, is dusted over with iodoform. In thirty cases thus treated there was rapid disappearance of pain, together with reductions of temperature to normal. Successful results were obtained in all but two instances, although some had already developed marked inflammatory signs.

## DR. FINLAY'S MOSQUITO INOCULATIONS.

Referring to the publications of Dr. Finlay upon this subject, Dr. Sternberg, (*Amer. Jour. Med. Sci.*, December, 1891), says:

As the editor of a prominent medical journal has devoted an editorial article to the subject in which he says, “the results would seem to show that this insect is a good attenuator of yellow fever virus,” I think it proper to make a few remarks with reference to these so-called “mosquito inoculations,” especially as I did not consider it necessary to refer to them in my published reports upon the etiology and prevention of yellow fever. I have not considered the subject as demanding serious attention, for the reason that *the mosquito does not inject the blood drawn from a yellow-fever patient into the inoculated individual, but it enters the insect's stomach, and whatever remains after its meal has been digested is passed per anum.*

When the mosquito introduces its proboscis into the individual who is to be inoculated it is for the purpose of withdrawing blood, and it is difficult to see how any inoculation can occur, unless some virus has adhered to the exterior of the delicate instrument during the considerable interval which elapses after one full meal before the insect can be induced to fill itself again.

This supposition, viz., that a minute quantity of virus adhering to the surface of the proboscis of the insect is sufficient to produce a mild attack of the disease in an unprotected person, does not appear very probable, and very positive experimental evidence will be required before it can be accepted, especially as we have some experimental evidence which indicates that the blood of an individual sick with yellow fever may be injected beneath the skin of an unacclimated person without producing any noticeable effect.

I know of no experimental evidence which goes to show that the blood of yellow fever patients contains the virus of the disease, and the yellow fever can be transmitted by inoculations with such blood. Before admitting that the virus can be attenuated by passing through the body of the mosquito, I think we should have some satisfactory experimental evidence that the infectious agent is present in the blood. But, as stated, if it were present it would be passed with the excrement of the insect, and not injected into the inoculated individual.

In Dr. Finlay's last paper he says:

"I infer that the insect has some way of rendering its outer surface aseptic, and probably does so through a very peculiar operation, which I have often seen it perform. This consists in collecting with its hind or middle legs a secretion expelled from the posterior part of its body, and besmearing very persistently with it every part of its body—legs, wings, head, and proboscis."

If the exterior of the proboscis is rendered aseptic by this operation, it is difficult to see how any inoculation can occur even if the blood of the yellow fever patient constituted the true virus of the disease.

The transmission of the *filaria sanguinis hominis* by the mosquito is a very different matter from the mode of transmission imagined by Dr. Finlay in the case of yellow fever. The embryo *filariæ* are taken into the body of the insect with blood drawn at night from the infected individual, and, according to Manson, undergo certain developmental changes in the intermediary host, and are subsequently discharged into water with the larvæ of the insect. Other individuals are presumably infected by drinking this water.

But the *à priori* objections raised against Dr. Finlay's so-called "inoculations" must give way if it can be shown that decided and constant results follow the application of a mosquito, which has filled itself with blood from a yellow fever patient, to an "unacclimated" person. We fail to find satisfactory evidence that this is the case. So far as I am aware, there has been no confirmatory evidence by other members of the profession in Cuba, and no one has felt sufficiently impressed with its value to repeat the experiments of Dr. Finlay and his associate, Dr. Delgado. I esteem both of these gentlemen very highly, and I would welcome most gladly a demonstration of the value of the method which they faithfully endeavored to test. But a justifiable scientific scepticism makes it necessary to demand more direct and satisfactory proof that the so-called inoculations produce any pathogenic effect, before any great importance can be attached to the results of Dr. Finlay's laudable efforts to discover a method of prophylaxis in yellow fever.

#### DECAY OF THE TEETH IN YOUNG MOTHERS.

A clipping in the *American Journal of Dental Science*, September, 1891, gives the following information:

1. The decay of the teeth shows a violation of the law of our beings. There is harmony and sympathy throughout our organisms. Pregnancy is a normal condition and is not responsible for decay of the dental organs.

2. Mothers who neglect the proper care of their mouths and teeth have decayed teeth, and mothers' teeth decay in proportion to their density and to the care bestowed on them.

3. That the sickness incident to childbirth and the care of small children takes so much time and care of the mother that she neglects her teeth for days, weeks and sometimes for months.

4. That the mother's maiden sisters and bachelor brothers have decayed teeth also.

5. The whole subject is summed up in the following, conditions being equal: Teeth decay—1st. In proportion to their density. 2nd. In proportion to their care and proper cleansing. Therefore, every mother and her maiden sisters should not only care for their teeth the best they know how, but they should visit a competent dentist frequently to have their mouths examined and get some wholesome instruction regarding the care of these most valuable organs.

#### TREATMENT OF HIP-JOINT DISEASE.

In an essay upon a certain point touching the treatment of this condition (*N. Y. Medical Journal*, November 28, 1891), Dr. Shaffer writes:

Operation is sometimes demanded by the circumstances surrounding the patient and by the expressed pathological conditions present, but I think it requires a very extensive experience and a more than ordinarily judicial medical mind to indicate the cases that would do well under an excision of the hip-joint.

On the other hand, the mechanical treatment, though often prolonged and generally tedious, promises better results to both life and limb than the operative measure. The conservative method may be more difficult; it may require prolonged training to make it successful, and our knowledge of the ideal mechanical treatment may yet be in its infancy; but I am assured that Nature aided in these cases is better than Nature forced, and my experience proves that it is better to await the self limitation of the disease under proper mechanical, constitutional, and climatic treatment, than to attempt the radical removal of a tubercular disease in an articulation where Nature has placed so many barriers in the way of a complete and satisfactory excision of the entire joint.

The best results are undoubtedly obtained under mechanical treatment in those cases where the condition is recognized and treatment is commenced in the first apparent stage of the disease—where we have only slight neuro-muscular signs and a slight limp as exponents of the disease. In many, but not all, of these cases, we may expect to secure perfect and free joint motion without any modification of rotation inward during flexion. After deformity and pain appear, and the neuro-muscular signs and the limp become pronounced, we may safely conclude that the integrity of the joint is seriously impaired; and we must work to secure the best attainable result, which may be a shortened member in good position, with or without movement at the articulation. And if some one among us will point out how we may secure early ankylosis in many cases of this class, he will earn a brilliant reputation.

My answer to the question which heads this essay “When may mechanical treatment be discontinued” is:

In the first apparent stage of tubercular disease of the hip-joint—where there is no deformity present and where we have only the neuro-muscular signs or the slight limp, or both, to guide us, as well as in the more severe stage of the disease where deformity is present, where tubercular disintegration of the joint has commenced, and where the muscular protection of the articulation is more pronounced—the only safe guides for discontinuing mechanical treatment are, first, the absence of the expressive attitude and gait of tubercular osteitis of the hip-joint; and, secondly, an essential modification or an abolition of the instinctive neuro-muscular protection of the articulation. And, further, I believe that in all but the exceptional cases a relapse as to the deformity, or the disease, or both, is likely to occur as the result of the traumatism of ordinary locomotion, unless proper mechanical protection is maintained until the articulation is free from true reflex muscular spasm or is ankylosed.



## EXAMINATION OF DRUGS IN MASSACHUSETTS.

The report of the committee for inspection of drugs in Massachusetts for 1890 (quoted in the *American Druggist*) fills a Marylander with regret that his State is still without protection against drug adulteration.

Of the 400 samples of drugs which were submitted for examination during the past twelve months, 75, or 18.75 per cent., were found not to be of their proper standard quality as called for by the laws of Massachusetts. For details the reader must be referred to the original publication or to the *Druggist*.

The following statements of the report in regard to cosmetics are also instructive and eminently satisfactory.

Within the past year there was a sudden increase in the number of empirical preparations used as cosmetics, and especially of certain articles advertised for the purpose of "improving or beautifying" the complexion. Upon examination of these preparations, several of them were found to be of an unusually poisonous character. They contained from three to eight grains of bichloride of mercury (corrosive sublimate) to the fluidounce, the principal ingredients being corrosive sublimate, water and a little tincture of benzoin. In the case of one of these articles—Madame Rupert's Face Bleach—it was further stated that "*it is guaranteed harmless, containing no arsenic, lead, bismuth, sulphur, lime, or anything injurious to the skin. Its effect is always beneficial.*" Another preparation—Madame Fale's Excelsior Complexion Bleach—put up in the same attractive form, is stated to be "*composed of strictly harmless ingredients,*" but was found on analysis to be nearly identical with the former and containing the same violent poison. These articles were heralded by glowing advertisements, and in the case of the latter a public hall in Boston was secured, a band of music, and a free lecture given for the purpose of introducing the preparation to the public. To the credit of the people, it should be stated that the audience was very small.

Instances of serious harm from the use of these articles came to the knowledge of the board. Complaints were made out against the agents who sold these two preparations in Boston, and at the trial, which took place in December, both were convicted and fined under the aforesaid statute. Two other preparations, bearing the names of Soule's Eradicator and Delisle's Royal Cream, were examined soon afterward, and found to contain corrosive sublimate in about the same proportion or strength. Parties selling these articles were also convicted and fined under the same act.

## FOR ACCIDENTS DURING ANÆSTHESIA.

From an editorial in the *University Medical Magazine* we obtain the following suggestions:

It should be a rule during anæsthesia to watch both the respiration and the circulation.

Should the respiration show evidences of failing, what shall be done? The anæsthetic is to be instantly removed; the tongue is to be brought well forward; and the throat is to be cleared of mucus or other obstruction; the head is then to be extended and the fingers hooked behind the angle of the lower jaw, which is to be brought well forward. This raises the epiglottis. This method is an improvement on that proposed by Howard, which consists in bringing the patient's head over the end of the operating table until it swings free, when it is carried backward and downward, until the utmost possible extension of head and neck is obtained. If voluntary respiration does not begin at once, some external stimulus is to be used. One always at hand is that pointed out by Hare (*University Medical Magazine*, Vol. 1, p. 105) of baring the abdomen of the pa-

tient and dashing a quantity of ether upon it. The rapid evaporation which follows produces a degree of cold, the shock of which frequently excites a deep inspiration. These means failing, artificial respiration is to be practiced without delay, preferably by the Sylvester method. If the appliances are at hand, the method of forced artificial respiration, as recommended by Professor Wood, is to be strongly advised. For this purpose, a pair of bellows, some rubber tubing, a face mask and a tracheal canula are needed. The apparatus can now be procured of instrument makers. The experiments of Wood have shown that the only respiratory stimulant worthy of mention is strychnine. In a stubborn case, the best results will follow prolonged careful efforts at artificial respiration. Ether is eliminated principally by the lungs; the expirations of the patient under ether being heavily charged with its fumes. If, therefore, full deep respirations are induced, and an abundance of fresh air supplied, the quantity of the drug in the body will be rapidly reduced.

If the circulation shows signs of failing, the anæsthetic should be stopped, and the same precautions looking to a free supply of fresh air are to be observed. A hypodermic injection of the tincture of digitalis may be administered at once. In the experiments just noted, no other drug was found to have a constant beneficial effect upon the heart. The action of ammonia is very evanescent. The hypodermic use of ether or alcohol in a patient whose blood is already saturated with ether vapor is as irrational as it is futile. Artificial respiration promises a great deal here also. Wood has resuscitated animals by this means alone after the respiration and the circulation had both ceased.

These various measures are to be employed, one after the other, more quickly perhaps than they could be described, and efforts are not to be relaxed while waiting for a certain article, but that means which is at hand is to be used until what is desired has arrived.

#### NEW REMEDIES

From a report by Dr. Wilson on Therapeutics (*North Carolina Medical Jour.*, Nov., 1891) we clip a few items:

Adonis vernalis is a new cardiac tonic similar in its effects to digitalis, is useful in dropsy and various heart affections. Its action is similar to digitalis in rendering the heart-beat slower, stronger and in increasing excretion of the kidney.

Ajowan, a remedy containing thymol, is claimed by Dr. Warring to be a most efficacious carminative; he also claims for it remedial properties in cholera. It has also been found to be valuable in alcoholism, and should be given a further trial in that condition. As an ingredient of poultices it is said to have the property of relieving superficial pain.

Balsam apple has been used in the treatment of colic with success; also as an efficient emetic was introduced by Dr. McNeil. Local pain-relieving properties are attributed to it. It is also recommended as a hydragogue in dropsy.

The preparations of jambul seed have recently been used for the relief of diabetic condition. Its effect is said to be due to its inhibitory action on the diastatic ferments, lessening the formation of sugar. The bark is also said to be useful. The facts in regard to this preparation justify a further trial for the relief of diabetic conditions.

Convallaria Majalis is a new cardiac tonic made from the roots, flowers or herb, the fluid extract of the root being the strongest. Its action is to slow and strengthen heart-beats. It is an active poison in over-doses; but has not

the disadvantage of a cumulative effect. It is also a diuretic. It is claimed to give relief when other tonics fail. Dose, 10 to 15 minims every six hours or *pro-re-nata*.

#### WOUND INFECTION.

Dr. Roswell Park closes an article upon this subject (*North Carolina Med. Jour.*, November, 1891), with the following summary:

1. Study of wound infection and of the septic condition thereby produced is inseparable from a study of what constitutes immunity.
2. By a study of immunity is furnished the best clue to a due appreciation of the principles of asepsis.
3. The surgery of the future must aim to be aseptic, for so far as fresh cases are concerned we have passed the merely antiseptic era.
4. Asepsis is to be achieved not alone by attention to the wound and the paraphernalia of operation, but by the closest regard to the condition of the patient's organs and tissues.
5. Sepsis may arise from circumstances and conditions other than those pertaining to the wound itself, although hitherto practitioners have been too prone to scan solely this field when searching for its cause.
6. Sepsis and infection are combatted in more than one way by natural agencies and by inherent properties of cells and fluids totally aside from the measures which the surgeon institutes, and the wisest man is he who studies to take advantage of these vital activities rather than introduce new and conflicting elements from without.
7. A recognition of the power of chemotaxis (the faculty possessed by leucocytes and perhaps by other cells of the human body of moving toward or away from certain substances which seem to attract or to repel them), possessed by organized and unorganized materials in such varying degree can be utilized to great advantage so soon as it can be reasonably clearly defined.
8. A study of this form of activity appears to impress one with the truth of the phagocyte doctrine, which, if proven, is one having a large bearing upon the principles as well as the practice of the surgery of the future.
9. The proteid material contained within cellular infectious organisms plays such a role in causing chemotaxis, as well as in poisoning the animal infected, that we have reason to eagerly welcome all knowledge concerning it.
10. So fast as such proteid material can be isolated we need, among other things, to study its effect upon the commonly used antiseptic agents.
11. We need to study much further the anti-toxic and bactericidal properties of human blood serum, and the means by which we can avail ourselves of the same.
12. Some such classification as I have attempted to give of the various causes of lowered resistance to infection, or of the causes of vulnerability or susceptibility, will certainly assist in a due appreciation thereof, and will often aid in so fortifying the patient that he may resist infection to which he would otherwise succumb.
13. The condition of enterosepsis, faecal toxæmia, stercoral intoxication, or whatever it may be called, is certainly one which every practitioner has to fear and against which he should assiduously guard. It is not sufficiently generally recognized and combatted.
14. A sub-form of this condition might justly be made and entitled gastrosepsis, comprising cases where defective stomach digestion, often from dilata-

tion. brings about a lithæmic or other toxæmic condition which favors infection.

15. Antiseptic agents in the past have worked a revolution in surgical practice and results. We have now reached a time when we know that they all have their disadvantages, and also understand how, if we are strictly aseptic in our work, we can afford to discontinue their application to wound surfaces.

### Medical Items.

Bordier proposes to inject negro blood into the veins of unacclimated white persons who contemplate a visit to the yellow fever zone.

The *Texas Courier-Record* relates that a Dakota woman has entered suit against a doctor for leading her husband into the morphia habit.

A French Court has decided that the person taking the initiative in calling a medical practitioner to a patient has thereby made himself liable for the fee.

The natives of the New Hebrides smear the points of their arrows with a swamp earth, the poisonous agent in which, according to Dr. Ledantec, is the septic vibrio of the tetanus bacillus.

At the meeting of the Practitioners' Club, October 26th, the ladies present were the prominent feature and the subject of discussion, taking a fair share in the entertainment and post-prandial discourse. From their many assertions it would seem that the life of a doctor's wife is full of special cares and deprivations. Dr. Henry M. Lyman presided.—*Chicago Medical Recorder*.

The Papyrus Ebers is said to be the oldest medical work in the world, dating 1550 years B. C. It has lately been translated into German by Dr. Heinrich Joachim. It consists mainly of receipts, interspersed with proverbs. In some passages advice as to the examination of patients is given. In other places the prognosis indicated by certain symptoms is given. By it we learn that the old Egyptian physicians practiced palpation of the abdomen.

The reformed inebriate who wrote the gorgeous advertisement for Keeley on the "Bichloride of Gold Cure" in the *North American Review*, a few months ago, relapsed after nine months' probation and died from the effects of a carouse, in the hospital on Blackwell's Island, New York, almost before the ink of his article was dry upon the pages of the magazine.

Arrangements have been made to issue in England quarterly a Journal of Pathology specially devoted to scientific memoirs on pathological subjects, doctrines of diseased actions, general pathology and bacteriology. It will be edited by Dr. G. Sims Woodhead, assisted by Dr. Sidney Martin and Dr. Armand Ruffer.

The department of pharmaceutical preparations, medical supplies, etc., has been for some unknown reason tacked on to the Silk Department of the Columbian Exposition. It is hoped this important branch of manufacture, with allied matters, such as surgical instruments and appliances, may be given an exhibit by itself under a competent head, and steps in that direction are being made.

Any one sending the following number of the JOURNAL in good condition will be paid ten cents for same: Vol. XXIV, No. 1, Nov. 1, 1890.

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NO. 560

## CONTENTS

<b>ORIGINAL ARTICLES.</b>		<b>OBITUARY.</b>
Appendicitis in the Female. By Thomas A. Ashby, M. D., of Baltimore. . . . .	155	Dr. Frank Donaldson. . . . . 167
Petition of the Clinical Society Touching City Sanitation. . . . .	160	<b>REVIEWS, BOOKS AND PAMPHLETS.</b> . . . . 168
<b>SOCIETY REPORTS.</b>		<b>CORRESPONDENCE.</b>
Clinical Society of Maryland. Stated Meeting held Nov. 20, 1891. A Peculiar Case of Epilepsy. 161		Do We Need a Law to Regulate the Practice of Medicine? . . . . . 168
<b>EDITORIAL.</b>		<b>MEDICAL PROGRESS.</b>
Physicians as Petitioners. . . . .	164	Progress in Physiology.—Cottage Nurses in England.—Ultimate Results of Removal of the Uterine Appendages.—No Salt in Sea Air.—A Strange Epidemic.—Lysæmia or Malarial Hæmaturia.—Electric Cataphoresis for Gout and Rheumatism.—Progress of Influenza in Europe. 168
A New Asylum for the Treatment of Mental Diseases. . . . .	165	<b>MEDICAL ITEMS.</b> . . . . 175
Chloroform in First Stage of Labor. . . . .	166	

### Original Articles.

#### APPENDICITIS IN THE FEMALE.†

BY THOMAS A. ASHBY, M. D., OF BALTIMORE.

Probably there is no condition within the abdomen which has received more careful study and discussion within the past two or three years than those inflammatory troubles involving the region of the head of the colon. The literature of this subject is enormous, and the various opinions which have been reached by practical workers in this region have given a definite rule for guidance in the diagnosis and treatment of the affection. Our knowledge of the subject has been so cleared up by the knife of the surgeon that few mistakes should now be made in the recognition and treatment of the disease in question. In former years, and even at the present time, these cases of appendicitis have been largely treated by the physician. It is only since the surgical aspects of the conditions presented have been more clearly recognized that the surgeon has been called upon to assist in their diagnosis and treatment. Recent studies have tended to place the disease upon a surgical basis and to remove its management from the department of medicine to the department of surgery. However strong may appear the argument in favor of this line of action, it must be admitted that in the larger proportion of cases a purely medical regime will be found sufficient to meet all the indications for treatment. Whilst most probably the majority of cases of appendicitis recover without the use of the knife, in many of these

†Read at the Semi-Annual Meeting of the Medical and Chirurgical Faculty of Maryland, Nov. 18th, 1891,

cases there are present the most pronounced indications for surgical interference. The skill required in all cases is to determine when to use the knife. Keen has tersely stated that "the first indication in appendicitis is to call a surgeon." This idea could be expressed more happily with the statement that the first indication is to recognize pus, for the question of medical or surgical management hinges upon the absence or presence of pus formation.

The presence of pus at once suggests the necessity for drainage and this indication disposes of the idea of a further medical regime. It may be safely stated that the chief danger in appendicitis depends upon the presence and behavior of pus accumulations. In a certain number of cases danger may result from extensive peritonitis without pus formation, but we must look upon pus as the most alarming signal calling for operative interference. Inflammations involving the head of the colon are, according to Morton, in 99 per cent. of cases limited to the appendix. The terms typhlitis, perityphlitis and extra-peritoneal abscess should be discarded. As the inflammation originates in the appendix, we may expect to find the entire trouble in this appurtenance to the intestinal tube. The diagnosis is not involved in serious difficulty if the case is seen in the early history of its progress. There is a point of sensitiveness and a well defined area of inflammatory induration in the region of the *caput coli*. Chill, fever, pain and constitutional disturbances mark the progress of the affection. In cases observed in the later stages of the disease the condition is far more difficult of recognition. This statement holds true especially when the trouble occurs in the female. It has been customary to speak of appendicitis as an affection peculiar to the male. Of 14 cases, Mynter found only one in the female; McBurney saw 24 cases, of which 21 were males and 3 females. Joseph Price reports five cases in which he has operated, all in women. In my own experience I have seen 5 cases, 3 in males, 2 in females. Price's line of work and my own would account for the more frequent observation of such cases in females. In the two cases in women which came under my care the diagnosis of appendicitis was not made until the abdomen was opened. Pus accumulations in women occur so frequently in the tubes and pelvic tissues that we may possibly overlook the influence of appendicitis as a factor in the causation of pelvic pus accumulations in this sex. This accident occurred in the two cases which I shall report. I had such strong physical signs of a pelvic abscess of tubal origin in one case and of an ovarian abscess or tumor in the other, that I did not discover the origin of an appendicitis until the abdomen was opened and the trouble at the head of the colon was found. There would seem to be no reason, in fact, why the female should be exempt from trouble involving the appendix to any greater extent than the male, and I am disposed to ascribe the differences shown by statistics to errors of observation and classification. May not pelvic abscess in women arise in the appendix and discharge through the vagina, bladder, or rectum, and heal spontaneously? It is well known that pus accumulations are disposed of in this way, presumably having their origin in a cellulitis. In one of my cases a termination of this character might have ensued had the case come under my observation before the pus sac had secured a natural outlet for drainage by the bowel. An unavoidable delay of a few hours prevented me from evacuating the pus sac *per vaginam* instead of, as afterwards, by an abdominal incision. I have reason to believe that the vaginal drainage might have resulted in a cure of the patient upon as good terms as that secured by the incision. My own experience goes to show that appendicitis may give rise to intra-pelvic abscesses in women more frequently than has been assumed.

The question of treatment for appendicitis can have little, if any, rela-

tion to the sex. Inflammations and pus accumulations in the abdomen must be dealt with upon equal terms, whether the area of the involvement be limited to the appendix, tubes or pelvic fascia. We may treat such conditions by rest, poultices, antipyretics or what not, but when pus forms and its presence is not tolerated, the knife must penetrate and search out the origin of the trouble and provide safe and perfect routes for drainage. That there is a similarity in the behavior of all forms of intra-abdominal pus accumulations I think cannot be denied. In appendicitis the pus sac is presumably shut off from the peritoneal cavity. This is the case with the pus tube, ovarian abscess and abscess sac in the pelvic fascia. Sooner or later rupture in either of these conditions may flood the peritoneal cavity. The outcome of the case will largely depend upon the condition of toleration or the outlet for drainage. In appendicitis the co-existence of a fecal abscess may enter as an additional factor to complicate the result, but as an offset to this accident we have a favorable circumstance in the better route of drainage which the intestinal tube provides in such cases.

The acuteness of the process in appendicitis has received large attention. The disease certainly runs its course in a very rapid way, tending to destroy life by the violence and rapidity of its stages. That it assumes a more chronic course my own cases tend to prove. I am prepared to believe that drainage in some way tends to retard the process, for where natural drainage has occurred a pus formation may go on for weeks and months. This fact very strongly emphasizes the importance of artificial drainage at the very first moment the pus accumulation proves intolerant or threatening. In the surgical treatment of appendicitis every case must be a law unto itself. In my judgment it is not judicious to establish fixed rules of conduct. The point selected for incision and drainage, the question of removal or non-removal of the appendix, the time for operative interference, must all be determined by the judgment of the surgeon and by the indications present in the given case. A careful study of the literature of this subject and of individual experience goes to show that the main point which should be kept in view is how to deal with pus, how to limit its extension, to cut short its septic influence and to provide for its safe and successful elimination. If it has selected unfortunate routes of drainage, if it has flooded the peritoneal cavity, if it is producing high temperature or toxæmia, the surgeon must at once interfere and change the conditions of its environment and influence. The technique involved in dealing with these problems is the same which should be observed in all similar conditions of pus formation of intra-abdominal origin. With these principles for our guidance we may approach the affection with reasonable hope of successful results by surgical intervention. To neglect or postpone surgical intervention under such plain indications, is to invite the most dangerous, if not fatal, consequences. Nature, it is true, is capable of working out the most difficult problems, and we owe to the influence of the *vis medicatrix* many favorable results in seemingly hopeless conditions. At this day of surgical knowledge and skill we are not warranted in a simple reliance upon a medical regime or upon nature's resources, which, whilst characterized by successes, show up a high rate of mortality. A comparison of present with former statistics shows the direct influence of surgery in lowering mortality and in the prevention of permanent forms of invalidism. As in other forms of intra-abdominal inflammations, we have in appendicitis the most trying test of judgment and experience, of passive observation or of prompt and intelligent action. Action or inactivity may be equally dangerous, and it is here that "discretion is the better part of valor."

CASE I.—Fannie, mulatto, aged 13 years, was picked up on the street by a policeman and sent to the Good Samaritan Hospital. Her condition at the time was extremely critical. The girl had neither home nor friends, and owing to her youth could give no accurate account of her previous history. She had been at service until turned out on the street and found by the policeman.

I saw her the day after her admission to the hospital. Upon examination, her abdomen was found enormously distended with fluid, her temperature was over 100°, pulse over 120, general condition one of extreme distress. In the right iliac region a hard, indurated mass was discovered, but owing to the distention of the abdomen, the tumor mass could not be outlined. The vagina was bulged out by the pressure of fluid above, so that the condition of her intrapelvic organs could not be made out. I had presumably an ovarian abscess or tumor to deal with, and decided to open her belly and remove the trouble.

Under chloroform, an incision was made in the median line and as soon as the peritoneal cavity was reached pus discharged in large quantities through the incision. The incision was extended and the abdomen explored. There were evidences every where of the most extensive peritonitis. The omentum and intestines were bound up in friable adhesions, and the abdomen was filled with pus, inflammatory lymph and necrotic tissue. On the right side, in the region of the appendix, a large mass of inflammatory lymph was deposited and the appendix and *caput coli* were tied up in the adhesions. The abdominal wall was thickened at this point and nature was apparently making an effort to drain at this location. I made an incision at this point, but did not disturb the lymph tumor. The abdomen was washed out thoroughly clean, and the intestines and omentum were put in as good condition as possible by removing adhesions, debris and small masses of lymph and of necrotic omentum. The upper portion of the incision was closed, but drainage tubes were placed in the wounds so as to provide as thorough drainage as possible. The temperature fell to normal by the next morning. The abdomen was flushed with hot water, carbolyzed, three and four times a day, through the tubes, for weeks. Five weeks later her temperature began to rise and pus ceased to flow through the wounds. I decided to drain the abdomen higher up, and to make better routes for the discharge of pus. Under chloroform the two incisions were re-opened and a third incision was made near the umbilicus, drainage tubes were again employed, and the abdomen was kept washed out as frequently as necessary. The patient's condition improved after the second operation, but the prolonged discharge of pus and confinement to bed told upon her general health. She was greatly emaciated and I feared she would die from anæmia and general debility.

To make a long story short, I found it necessary to open the abdomen upon two subsequent occasions to secure better drainage and to open up new pus pockets. After some six months of constant attention, pus ceased to discharge, and her recovery was assured. She passed out of my care about the latter part of August, a comparatively well patient. The origin of the pus was at first in some respects obscure, yet in the light of a subsequent study of her case, I came to the conclusion that an appendicitis had started the conflagration. The pus sac ruptured into the general peritoneal cavity and a suppurating peritonitis ensued, which filled the entire abdomen with pus. With drainage and cleanliness a recovery was accomplished.

CASE II.—Mrs. P., aged 24, 1-para. This patient came under my care Aug. 13, 1891. Her history indicated one month's illness. During this time she had consulted some three or four physicians. The date of my first visit I found



upon vaginal examination an enormous intra-pelvic abscess. The patient's condition and surroundings were very unfavorable. I at once advised her friends to send her to the Union Protestant Infirmary, where she could receive proper treatment. I at once jumped to the conclusion that I had a pelvic abscess to deal with and presumed that it was of tubal origin. The patient stated that she had discharged, the day before I saw her, some pus by the bowel. I found at that time no evidence of drainage and felt confident either abdominal or vaginal drainage should be employed at once. I decided to operate as soon as she entered the hospital. Three days intervened before she could be carried to the hospital. During this time pus escaped in large quantities per rectum. After entering the hospital I found the intra-pelvic tumor growing less from day to day by large discharges of pus by the bowel; her temperature fell, pain grew less and general condition improved. I decided not to operate until symptoms warranted interference. She discharged over one pint of pus daily for some six or seven days. As long as natural drainage was free I had a slight hope that a spontaneous cure might take place. With stoppage of the flow the pus tumor began to enlarge, pain returned and her temperature went up. I then advised a laparotomy, still holding the opinion that I had a pus tube to deal with.

On September 1st, I opened the abdomen and much to my surprise found the origin of the trouble in the appendix. Both tubes and ovaries were diseased but the tumor which gave rise to the pus was a dense inflammatory mass, filling the right side of the pelvis and completely inverting the appendix and *caput coli*. It was shut off from the peritoneal cavity and, strange to say, did not involve the abdominal muscles. It was in communication with the colon and the pus had made its way through the bowel by this route. The appendix was tied up in the adhesions but its lower end could be drawn out. It was filled with fluid, but in good state of preservation. As the abscess sac was not opened and was discharging into the colon, I decided not to disturb the relations, but to place a drainage tube through the incision and to provide a better route for drainage should an effort be made in this direction. I apprehended that the tube would be closed in by inflammatory lymph and that an extra-peritoneal route would in this way be made along the course of the tube for pus or fecal matter, should an opening into the sac occur. I hoped to be able to divert the stream by the new route without disturbing the bed of the old route by the colon. The results established the correctness of this plan. The patient bore the operation extremely well. Her bowels opened daily in a natural way, and some pus was found in each stool; after the fourth day all pus ceased per rectum. On the eighth day the pus began to come by the abdominal route and along with it some fecal matter and large quantities of green intestinal mucus and fluid. The discharge was removed by syringing out the tract left by the drainage tube. Everything was kept clean. There was not a single unpleasant or disturbing symptom. For some six days the wound poured out intestinal mucus and pus in lesser and lesser quantities, and finally ceased. The patient made a thorough and entire recovery.

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A new cottage hospital has been planned, for the treatment of women, in Boston Harbor. It will be located on property belonging to the city on Long Island. The first ward building that will be built will be one hundred and forty feet long, with a capacity of one hundred beds. The amount of the appropriation is fifty thousand dollars, with an increase expected in future years.

PETITION OF THE CLINICAL SOCIETY TOUCHING  
CITY SANITATION.

(See Editorial Column.)

Realizing the importance of public sanitation in a great city like Baltimore, and desiring to support the Health Officer in his efforts after improvement in this department, the Clinical Society of Maryland, a representative body of physicians, in regular session assembled, at Baltimore, December 4, 1891, having received from its special committee on Public Health a careful report upon the sanitary condition of Baltimore, does by this resolution present to the Mayor and City Council the following respectful petition:

First—That the force of City Vaccine Physicians, which has recently, by report of the Health Officer, been declared much too small to perform the duties of public house-to-house vaccination, be at once increased in such a way that the community may be duly protected against small-pox, and that the most capable physicians who can be obtained be hereafter appointed upon this force without reference to political creed.

Second—That the necessary measures be adopted to prevent that foulness and unhealthfulness of the city water supply (or of that portion of the supply which is obtained from Lake Roland) which occurs every mid-summer and which is ascribed to defective construction of Lake Roland, to the reception by that reservoir of surface drainage from the surrounding populous country, and to the existence of dead-ends in the city water-mains in which the water becomes stagnant.

Third—That means be taken to prevent the erection of dwelling houses upon ground which has not been provided with necessary appliances for draining away its surplus moisture and keeping it drained; and to prevent the filling-in of building lots with any material other than fresh, dry, wholesome earth. Such practices establish in the homes of our citizens breeding places of disease which, for generations, may silently but surely destroy the health and lives of the inmates.

Fourth—That laws be enacted to regulate the use of night-soil for manuring and forcing vegetables in the districts adjoining Baltimore, since scientific investigation teaches that the manuring of esculent plants and the sprinkling of vegetables (eaten raw) with liquid night-soil may be a powerful agent in the causation and spread of disease in the community.

Fifth—That efficient agencies be established by, and under the control of the Health Office, for the protection of citizens against the sale of diseased and unwholesome meats and other food products, which are brought to our markets, even after they have been excluded from other cities.

Sixth—That public urinals of such form as shall not offend the sense of delicacy, be established at proper intervals along our streets and about our markets, so that persons may not, for this cause, be compelled to go into neighboring drinking saloons.

Seventh—That the Chief Health Officer receive authority over all the sanitary departments of the city, including that of street cleaning, so that he may have power to direct their activities and may be held responsible to the people of the city for any neglect of duty with which such departments may be charged.

Eighth—That the office of Sanitary Inspector be now and in future bestowed only, without respect to political creed, upon medical men who shall, by public competitive examination, prove their acquaintance with the principles of Sanitation and Hygiene and their fitness in other respects for their tasks, and that

they be allowed to hold their positions so long, and only so long, as they shall properly discharge their duties. Under these circumstances the Health Officers would obtain what they now lack and what is essential to their highest usefulness—the sympathy and the co-operation of the medical profession. This sympathy and co-operation in the matter of the notification of infectious disease is withheld by medical men of prominence on the ground that the Sanitary Inspectors are not fitted for their work, and that as a consequence no important good to the community is likely to follow their visits of “inspection.”

Ninth, and finally.—That efforts be made to secure from the legislature of the State such privileges of local self-government by Baltimore City, that such enactments may be from time to time made by the city legislators as shall be necessary to the establishment of these important sanitary improvements.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOV. 20, 1891.

The 257th regular meeting of the Clinical Society of Maryland, the President, Dr. Robert W. Johnson, in the chair.

*Dr. K*—— made an impromptu report of A PECULIAR CASE OF EPILEPSY.

*Dr. K*—— said: My patient, whom I treated for two years, was a woman 40 years of age, who in childhood had occasional convulsions until her 13th year. The attacks then ceased, and until her 38th year she had no recurrence of convulsions; but all her life from her earliest recollection she had frequently, as she described it, a very peculiar sense of “rising” from the stomach, like a wave, which passed upwards until it reached her head, and then vanished. This was not associated with any subjective sensation of light, sound or taste. It would doubtless be regarded by any medical observer as an epileptic aura or a paroxysm of *petit mal*, yet from her 13th to her 38th year she had no attack which resembled *grand mal*. She had found that when a “rising” threatened she could prevent it by taking a drink of water; but at this time she could not gain “courage enough to lift a glass of water to her lips,” although she could ask for it and could drink if some one else held the glass to her lips.

When I was first called to the case, the patient had just had her first paroxysm of *grand mal*. She lay in a dreamy stupor, answering very intelligently when questioned. She had bitten her tongue, as she did several times subsequently. I made a diagnosis of epileptiform convulsions.

I then put her upon bromide of potassium in doses of from 30 to 60 grains three or four times daily, and afterwards of only 30 grains at night, which latter was sufficient to deprive the fauces of tactile sensation (Hammond’s test). Later I gave 30 to 60 grains of bromide of sodium in the same way, but it was not as efficient as the bromide of potassium.

Under this treatment the risings ceased and no convulsions appeared. The patient after about three months discontinued the drug and a second convulsion occurred. Ever since this she has had them at intervals of three or four months, sometimes singly, sometimes two, three or four in succession during twenty-four consecutive hours. After attending her for several months I became aware that the patient presented a periodical tendency to the recurrence of the convulsions. There would be about three weeks of apparently perfect health, then the “risings” would become gradually more numerous and severe, the face would as-

sume little by little a dark and forbidding look. In addition to this, other symptoms would make their appearance, such as "nervousness," coldness of hands and feet, or a sense of fatigue on exertion. This condition would become more and more threatening during about one week, when it would either be remedied by purges and other means, or would end in an attack of *grand mal*.

Observing this peculiar remittance in the progress of the case, and being unwilling anyhow to keep the patient continually on drugs, I determined to leave the three weeks of "remission" free from treatment except careful diet, general tonics or an occasional aperient, and to devote my energies to the week in which the crisis or climax threatened. This determination of mine was reached only when several months trial of full doses of the bromide of potash showed that they did not break up the "epileptic habit" and that the drug was intolerable to the patient on account of the heaviness of mind, dermatitis, and pruritus caused by it. In accordance with my new plan, whenever the "week of crisis" recurred, marked by the above-mentioned symptoms, I placed the patient at once upon very active treatment, large doses of Epsom or Rochelle salts, bromide potassium or sodium, with benefit. Inferring from the coldness of the extremities and dark congestion of the face that the phenomena of the "week of crisis" were due to the collection of sluggish blood in the internal organs, especially in the brain, I tested also the effect of agents which equalize the blood circulation and relieve local congestion. Aconite and tartar emetic each in turn seemed to be of benefit in relieving the symptoms of the "week of crisis." I found, however, that when the symptoms of one of two such "crisis weeks" were controlled, they appeared with renewed intensity at the following "crisis week," and in no instance was I able to ward the convulsion off for more than four months. During and just before a convulsion the face would be dark, the limbs cold, and the pulse very hard and full. This state of the pulse would continue until the convulsion or series of convulsions was ended, and then the pulse would be soft and natural. I learned to tell thus by the pulse whether any convulsion would be followed by others or not. On one occasion the application of several wet cups between the shoulders produced this change in the pulse and prevented a convulsion. On another occasion the cupping softened the pulse a little, but in a few minutes it became hard again, and a second convulsion followed, and a third, until the bowels were moved by Epsom salts, and undigested material was vomited, when the pulse became soft and continued so, no more convulsions occurring. Nitrite of amyl inhalations, from three minim pearls, seemed on several occasions to ward off threatened convulsions for a time.

Chancing to examine the abdomen, I found several uterine fibroids two or three inches in diameter and an ovarian cyst about four inches in diameter, but these caused her no inconvenience. Moreover, although the "crisis" occurred often exactly four weeks, or its multiple, after the last convulsion, yet exceptions to this rule made it evident that the convulsions were not necessarily associated with the menstrual periods. The menstrual function was in every respect normal. The convulsions seemed in every case to be associated with sensations in the stomach, and mustard plasters over that organ appeared to have a soothing influence. The mental vigor of the patient did not deteriorate, and the earning of the daily bread was interrupted for only two or three days after each attack of *grand mal*. I did not attempt to induce her to give up her employment, although it required great expenditure of mental energy; because she felt better when she was thus occupied than when she staid at home in bed or took a holiday.

*Dr. W. S. Gardner:* The doctor said the woman had small fibroid tumors. If the woman has fibroids, these might cause hæmorrhage at any time, of any

amount. We do not know positively that ovulation and menstruation come on at the same time and this tendency to convulsions may come on at the period corresponding to her period of ovulation, and I think from what he has said that there seems to be a connection between the convulsions and either the menstrual or the ovulation period, as it is when she has a congestion of the pelvis that these attacks come on and these attacks are relieved by cathartics, etc.

*Dr. Branham:* It seems to me that such simple treatment as an emetic would be likely to do as much good as anything in a case of this kind.

*Dr. Chambers:* Epileptic convulsions do not tend to run such a regular course as once in four weeks. It does not seem to matter whether this patient is given an emetic, bromide, plaster or cupping; she does equally well under all treatment. Anyone knows that epilepsy does not seem to do equally well under all sorts of treatment. I do not believe there is any connection between her improvement and cupping. The case does not resemble the ordinary clinical history of a case of epilepsy. It seems strange that our gynæcological friends, knowing that she had fibroids, should allow the case to go on every four weeks.

*Dr. Alice T. Hall:* Disturbance of the stomach, which so many women have, is very apt to be connected with such convulsions. These disturbances of digestion are very common in women and seem to come on at the time of ovulation or menstruation more or less regularly in hysterical women.

*Dr. K——:* Dr. Chambers does not believe it is epilepsy.

*Dr. Chambers:* I did not say it was not epilepsy; only that if it is, it is a peculiar case of it.

*Dr. K——:* I recognize epilepsy as very distinct from hysteria, but hysterio-epilepsy may be confounded with epilepsy. I have not met with a case of hysterio-epilepsy, but my opinion of these cases is that the patients are at all times somewhat hysterical. This person is in no sense a hysterical woman and in the attack possesses not the faintest idea of what is going on. In regard to the treatment, I did not say that all treatment will give the same result. Bromides will meet the case if given in time and in large enough quantities. Cupping failed the last time—two or three convulsions followed it. My idea of epilepsy is this: it is a symptom common to a whole series of disorders and is not confined to one particular condition of the nervous system. My patient has, I suspect, a peculiarly sensitive nervous system and there appears to be, at the time of the convulsion, a collection of sluggish blood in the great centres, as the limbs are cold for days before the paroxysm comes on. As to an operation, my patient would not submit to one, and I myself do not believe that the symptoms justify the risk of life which such an operation would involve. I would like to caution Dr. Branham not to give an emetic when a patient is threatened with convulsions, for he may possibly have the whole contents of the stomach poured down the larynx, causing death.

1603 N. Broadway.

W. T. WATSON, Rec. Sec'y.

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#### NITROGLYCERIN FOR ASPHYXIA.

In a case of asphyxia from the inhalation of illuminating gas, Hoffman (*Allgem. Med. Ztg.*) succeeded in relieving the symptoms by the subcutaneous administration of nitroglycerin in doses of a hundredth of a grain. The injection was made in the precordial region, and was followed by marvellously prompt results.—*National Druggist.*

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BALTIMORE, DECEMBER 19, 1891.

**Editorial.****PHYSICIANS AS PETITIONERS.**

The Clinical Society of Maryland has recently appeared in a new role before the public. In consequence of the presentation of a paper on certain sanitary matters by one of its members November, 1890, the society appointed a committee to review the sanitary condition of the city, and to suggest in its report any improvements which might properly be considered by the Society. The committee has now made its report, which was received with attention and interest. It has also offered a petition, which was adopted by the Society and ordered to be presented to the Mayor and City Council of Baltimore. This is published by us in a column of this issue. As both the report and petition have been published in the *Daily Sun* (of Dec. 5), the people of Baltimore cannot accuse the medical profession of lack of interest in the sanitary welfare of the city.

It is to be hoped that other medical societies will take action upon these important subjects, and will allow their opinions to be published in the daily newspapers. It is urged by some that the Clinical Society ought to attend exclusively to clinical matters, but, as one of its members recently remarked, "if the Clinical Society doesn't move in the matter, who will?" The sanitation of the city is a subject which touches the life and health not only of the laity, but of the physician and his family. The public does not understand the needs of the case; the physician does, therefore he should act first in the matter. The city authorities do not care for the medical journal, but they do fear the public press. Therefore, let the profession publish its sentiments in the daily newspapers; and this, not once, but again and again, as occasion demands.

## A NEW ASYLUM FOR THE TREATMENT OF MENTAL DISEASES.

The Sheppard Asylum, which has been under construction for nearly thirty years, has now been opened to patients. The institution is the gift of Moses Sheppard, a member of the Society of Friends and a successful merchant of this city. The sum of half a million of dollars with which the Asylum is endowed, was set apart for this purpose several years before the death, in 1857, of its founder, who for four years presided at the councils of his chosen board of trustees.

The Asylum is situated in a beautiful section of undulating country on the line of the Baltimore and Lehigh R. R., six miles north of Baltimore, the post office address being Towson, Md. The buildings are very carefully constructed according to the most advanced principles, and are fire-proof. Each ward has one or two large "sun-rooms," made attractive by growing plants. Each room is lighted by electricity. The institution is open to the unfortunate of both sexes and of every creed and condition in life. Its accommodations are suited to the demands of the wealthy, yet it is designed that its benefits shall be shared as well by persons of humble means. The institution is entrusted to the care of Dr. Edward N. Brush, late of the Pennsylvania Hospital for the Insane, who has the title of Physician-in-Chief and Superintendent, and to his assistant, Dr. D. Meridith Reese, formerly assistant at the Johns Hopkins Hospital.

By the wish of the founder, the institution is designed to carry forward and improve the *ameliorated system* of treatment of the insane without regard to expense, the income only of the endowment fund being used. He directed that each patient should have a separate attendant when it should appear useful, even though the expense to the institution incurred thereby should limit the number of patients. His design was for a hospital for the *cure* of the insane and not an asylum for the care and safe keeping of chronic cases.

The *ameliorated system* of treatment is that instituted by Pinel in Paris and by Tuke in England, according to which all unnecessary restraint and severity is done away with and persistent effort is made to restore the disordered mind to health through the kindly influences of cheerful surroundings, agreeable employment, bodily comfort, and the sympathy and counsels of a skilled and companionable attendant. The use of deceit in dealing with the patient, either in getting him into the asylum or in managing him while he is there, is especially avoided.

The Sheppard Asylum is welcome in this community, not only as an institution which will year by year bring comfort and perhaps health to its inmates, but also as another of those great agencies for the higher investigation of disease and its treatment, which, through the magnificent gifts of our fellow citizens, are gaining for Baltimore and Maryland the respect of the civilized world and are helping to lay deep the foundations of the "Medicine of the Future."

## CHLOROFORM IN FIRST STAGE OF LABOR.

The sovereign efficacy of chloroform in all of the severe operations called for by abnormalities in the structure of the maternal parts or by false positions of the child is universally admitted. The extent to which this drug should be used to relieve the ordinary sufferings of the mother, especially those of the dilatation stage associated with unnatural rigidity of the cervix is, however, still in dispute.

Many physicians give chloroform in every case, or in nearly every case of parturition, being impelled simply by a desire to save the patient from pain. The obstetric record of these gentlemen appears to be excellent, and they are often men of large midwifery practice.

Others either withhold chloroform as long as they possibly can or else positively refuse to give it, unless in grave emergencies; seeking to soothe the patient and to relax rigidity by the administration of the bromides, chloral, etc. Many of these physicians, too, control large obstetrical practices. Among the objections urged by them are these: that, if the administration of chloroform is once commenced in the first stage of any case, it must be continued throughout the whole labor, as the patient and her friends will positively demand its continuance, and that such administration, throughout a labor of several hours, may injure either the mother or the child, or both; that imperfect contraction of the uterus after labor, and post-partum hæmorrhage, are apt to follow the prolonged use of chloroform in this way.

The question seems to narrow itself down to this: Can the intensity of the pains of the dilatation stage be appreciably assuaged by the wise use of only a very small total amount of chloroform? If it can, then most accoucheurs will prefer to use the drug in a large proportion of cases. If the administration of chloroform once, early in the first stage, necessitates the subsequent use of a large or dangerous amount as the labor progresses, then most accoucheurs will prefer not to use it unless in rare emergencies.

Recently the editor has had experiences which teach him that in certain, if not in most cases, very little chloroform will suffice. Attending a case at night and not being able to easily procure chloral, he allowed the patient to inhale about half a drachm of chloroform from a flatly folded handkerchief in order to take the edge off of the very severe pains which were associated with very slow dilatation of the cervix. During the hour or two which elapsed before the second stage set in, he satisfied the patient and gave her great comfort and rest of mind, by allowing her to smell, during each pain, the handkerchief, either free from odor of chloroform or slightly scented by having the moist cork of the chloroform bottle pressed against it. Not more than a drachm of chloroform was used in all, yet great comfort to the patient, and probably some relaxation of the rigid cervix, were obtained. After the cervix had completely dilated and the second stage had begun, the patient was actively occupied with the business of



expulsion and did not desire to smell anything. There was no post-partum bleeding as there had been in former labors without chloroform.

Subsequent experience has taught him that at least some parturient women, at the acme of a severe pain, do not know what they are inhaling or whether they are inhaling anything at all, but get great comfort from crowding a handkerchief, supposed to contain chloroform, down upon their nostrils and sniffing at it. With such a patient the doctor can use, in the way indicated, as little chloroform as he pleases, securing the effect of the drug in relaxing the cervix and in controlling the most violent pains.

The vomiting which sometimes results from the inhalation of chloroform is beneficial in relaxing the cervix. If chloroform can thus be safely given, there can be no doubt that it ought to be given in all cases of severe labor where there are no special contra-indications to its use. If the parturients were men, the question would probably have been so decided long ago.

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### Obituary.

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#### DR. FRANK DONALDSON.

Dr. Frank Donaldson died Wednesday morning, December 9, at his residence, 510 Park Avenue, in the 69th year of his age. In his decease the profession, not only of Baltimore, but of America, has lost one of its most active workers and most faithful and efficient physicians.

The medical training of Dr. Donaldson was begun at the University of Maryland School of Medicine, from which he graduated in 1846, and completed during a residence of two years in Paris, where he received the benefits of clinical observation offered by the great hospitals, under the guidance of famous French teachers.

At the time of his death he was Professor Emeritus in the University of Maryland School of Medicine, having for twenty-two years faithfully served his Alma Mater, first as Professor of Physiology and afterwards as Clinical Professor of Diseases of the Throat and Chest. The physicians of Maryland, in 1881, expressed their appreciation of his professional merits by electing him to the highest medical office in the State, that of President of the Medical and Chirurgical Faculty.

Dr. Donaldson did not confine his practice exclusively to his specialty, but in addition to his special and consulting work in throat and chest diseases, in which he had no superior, and to his duties as examiner in many life insurance companies, possessed until near the time of his death an extensive general practice. As a medical writer he was well-known, not only in the societies of the State, but in the various special and national associations of the country.

We deem it unnecessary to comment upon the faithful and self-denying care, which, in common with all true physicians, he bestowed upon those who committed themselves to his professional charge, or to speak at length of his private life as a consistent member of the Protestant Episcopal Church.

We must, however, testify our appreciation as medical men of the readiness which Dr. Donaldson ever showed to aid in the advancement of enterprises beneficial to his profession, and to his willing contributions of books and money to the medical library of our city.

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**Reviews, Books and Pamphlets.**


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*The Review of Reviews.* Monthly, illustrated. An International Magazine published simultaneously in the United States and in Great Britain. New York, Astor Place. ALBERT SHAW, Editor. \$2.50 a year.

This "Busy Man's Magazine," an electrotype of which appears in our advertising columns, is cordially recommended by us to our readers. The December number before us contains 149 pages of reading matter, illustrated by nearly a hundred portraits of men and women who lead in the activities of the political, philanthropic and literary spheres. We are sure that any busy physician who desires to keep up with the times and at the same time to have upon his office table an attractive and interesting journal, will find in the "Review of Reviews" just what he needs.

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**Correspondence.**


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DO WE NEED A LAW TO REGULATE THE PRACTICE OF MEDICINE?

BALTIMORE, DECEMBER 15, 1891.

*Editor Maryland Medical Journal:*

Almost daily we find sufficient reasons to bring up this question. This fact is established; viz., that the profession of the State not only wants, but actually needs a law to keep back that nuisance, known as the great and only Dr. So-and-So, late from this or that great hot-bed of sickness. By a large majority of the profession, the question is settled in the affirmative. There are some members of the profession for reasons (?) best known to themselves, are either on the other side of, or on the fence. To them this question is addressed. An attempt was made two years ago to secure a *passage* of and the *signature* to a bill that would have given satisfaction. All credit to those gentlemen for their efforts; but to-day we are in the same place that we were two years ago. Why? Because "*the signature*" to the bill was not secured. By the way, when you gun for big game don't use small shot.

That, however, "has nothing to do with the case." Let us not forget what was accomplished, but take that as showing what can be done by sensible people, with sensible people. Let us with renewed vigor gather the forces and push our fight to that same desk but, thanks to a wise people, not the same man, nor "his kind."

The leading members of the profession should take this in hand (outside of any organization), and effect an organization, each county being represented as well as the city of Baltimore. Why could not the deans of each school in this city (six in all, I think), get together and make arrangements and issue a call to the State, asking each county to elect a member to the working committee.

"CONFECTIO ROSÆ."

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**Medical Progress.**


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PROGRESS IN PHYSIOLOGY.

The effect of instruction of the children of our schools in physiology is awaited with interest. The reflections of the youthful mind on its deep mysteries are sometimes worthy of record.

Recently a course of instruction in physiology was given to some little girls

in one of our schools. The manner in which birds digest their food and the extra labor which is imposed upon the digestive organs in consequence of the absence of teeth in the "feathered tribe," was carefully explained to the wondering minds of the little maidens. Some days later a member of this physiology class was found discussing the subject with some other little girls and revealing to them an original discovery to which she herself had been led by her physiological studies. This discovery was, that her grandmother, with whom she lived, had a gizzard. The truth of this startling assertion she maintained with confidence, resting her conviction on the fact that the old lady had no teeth and on the logical deduction that, according to the principles of physiology, in such cases the crushing and subdivision of solid food must be performed by the internal organs. Her logical inference was about as correct as the speculations of some older folks, and the spirit of investigation exhibited showed the true scientific spirit.

#### COTTAGE NURSES IN ENGLAND.

The subject of village and rural nursing continues to exercise greatly the attention and judgment of those who, from their position and experience of country districts, are most likely to arrive at wise conclusions as to the means of obtaining the best class of women to attend the sick poor, at their homes. At a recent annual meeting of the Hereford Diocesan Conference, and at an important conference of ladies held at Liverpool, the question of rural nursing occupied a prominent place. District nursing differs essentially from hospital and private nursing, inasmuch as in the former case the nurse has more responsibility than she would have in a hospital or Poor-law infirmary. On the other hand, the *status* of the district nurse has hitherto been considered inferior to that of the hospital or institution nurse, mainly on account of the small remuneration offered. There are several organizations already at work. One of these employs young women of the peasant class, of respectable character, without much (if any) hospital experience, but who have had a fair training in district and midwifery work; while the other insists that the nurse should have at least twelve months' training in a hospital, three months in some lying-in establishment, and six months in district work. The first system, which is the outcome of the work of several philanthropic ladies, has certain advantages associated with it which it would be unjust to ignore, and which have induced the Council of the Jubilee Fund to federate them in a measure with the Queen's nurses. The advantages relate to the readiness of the nurse to undertake ordinary domestic duties, such as cleaning, cooking, and the care of children when the mother is ill, and to put up with the food and scant sleeping accommodation of a laborer's cottage. The cost of maintaining them does not amount to one-half of the cost of a fully-trained nurse. There is, however, a growing feeling that the same skilled nursing which is now almost the exclusive property of the rich should be extended to the poor, and this is practically impossible if the nurse is expected also to combine her proper duties with those of a charwoman. Committees prefer to employ the best trained class they can obtain, and do what they can to promote their comfort and well-being, so that their prestige and position may be maintained in the locality. District nursing of this character has many prejudices to surmount before it can be established on a firm basis; it will require much tact and forbearance on the part of those inaugurating a new system to take the place of the old. Each district possesses its own peculiarities to be dealt with separately, but at the same time with a unity of purpose essential to the success of every well-devised scheme of nurse organisation. **The commercial view of the question is one which cannot**

be lightly passed over. The fact cannot be disguised that the best class of women will not undertake district work unless they are adequately remunerated, and their nursing is made to hold a high place in public estimation. It is no criterion of the success of any nursing organization when the ruling authorities report with a certain amount of gratification that the cost of each nurse separately does not amount to more than £40 to £50, or even £70 a year. We know very well that suitable lodging accommodation, board, uniform and competent salary, together with some means of conveyance for long distances, and a few necessary appliances for the sick room, must involve a very considerable outlay, and the Council of the Queen's Jubilee Fund for nurses has acted wisely in estimating this at £100 a year. The development of the various schemes for rural nursing now afloat will be watched with interest. Wisely directed, they are destined to become a great boon to the sick poor as well as of essential service to country practitioners.

This movement in England which is thus chronicled in the *Brit. Med. Jour.* deserves our attention, inasmuch as it will soon be found desirable to initiate it in our own country.

#### ULTIMATE RESULTS OF REMOVAL OF THE UTERINE APPENDAGES.

In a paper (*N. Y. Journal of Gynecology and Obstetrics*, December, 1891), reviewing the after-history of 26 patient upon whom laparotomy had been performed from five to eight years before, Dr. Lee presents the following conclusions:

1. That relief of pelvic pain has come but slowly, usually after the first year has elapsed, yet completely in all the cases where the appendages were structurally diseased. In the neurotic cases it is in some instances still persistent.

2. The secondary local effects of operations have quite often seriously affected the patient's after-health. Thus in six (of the twenty-six) cases menstruation continued for periods varying from two months to two years. In six cases, also, more or less perimetritis occurred and much retarded recovery, although leaving no permanent disability. In two, acute cystitis and subsequent vesical catarrh occurred and they have since relapsed.

In one, secondary hæmorrhage from an apparent hæmorrhagic diathesis followed operation, and the patient was only saved by transfusion. (Another more recent case, in October, 1887, has also required transfusion; but this, being less than five years old, has not been included in the table.)

3. The remote effects on the nervous system and general health have been almost uniformly good where the section was done for structural disease of the appendages. The most satisfactory results come but slowly, generally after the first year. More than this Dr. Lee thinks it is unsafe to promise in any case, however favorable it may appear. But in no single case has the patient become completely well where section was done for neurotic conditions. Three cases of epilepsy are specified, and of these, two are still epileptic, and the third is somewhat feeble-minded and hysterical. These, although the only such examples cited in the table, form but a small part of the cases of like import which have gradually passed out of the reader's knowledge and to which he looks back with mortification and regret.

4. Little or nothing can be reported of the effect of the operation on the sexual appetite, as few patients seem willing to reply on this head. The reader thinks it, however, of little importance from any point of view.

Finally, as to the causation of mental depression or derangement as a remote effect of removal of the appendages, the reader's opinion was emphatic,

In no single case has he found patients to lament what was done or exhibit mental depression, except when discouraged by complications retarding their recovery. This is not chargeable to the specific operation, but simply an evidence of continuing invalidism. The epileptic cases have continued as before; the neurotic subjects irritable, depressed, unhappy and practically unchanged; but the patients whose health was being undermined by acute or chronic structural disease of the appendages almost uniformly improve, mentally as well as physically.

#### NO SALT IN SEA AIR.

Dr. Friedrich, of Dresden, combats the view that winds, especially easterly winds, cause the removal of the salts from the sea water and their more or less general dispersion. The author quotes in support of his own view a large number of old and modern works, and adds to these the results of his own experiments. From these it appears that sea air, as such, contains no salts at all, and that its saltiness, both at sea and on shore, results from infinitesimal particles of the water dispersed by the waves and tide, while currents of air cause the further distribution of the finest saline particles. He denies that evaporation contributes to the presence of salt in the sea air. The salt found in plants near the coast has the same origin as that in plants at some little distance. It is caused by meteoric water, which always contains chlorides. These chlorides are present in greater quantities on the coast because the humidity is greater and more frequent, and larger deposits take place. The value of the sea air for therapeutic purposes is also, he believes, not due to the presence of salt, but to the greater humidity, purity, and density of the air, as well as to its more uniform composition. In view of other observations, Dr. Friedrich does not dispute the favorable influence of the greater quantity of ozone, but he lays particular stress on the fact that, to be of good and permanent effect, the treatment of serious cases, especially of chest affections, must be undertaken in a suitable climate and a favorable situation. Even there a real improvement and permanent cure cannot be expected in from four to six weeks, but requires a repetition of the treatment or a stay of some months.

The editor of the *Sanitarian*, from which we quote this, says that he published an article to this effect, showing the purity of sea-air, thirty odd years ago.

#### A STRANGE EPIDEMIC.

The *British Medical Journal*, November, 28, 1891, publishes a preliminary notice of a remarkable, perhaps unique, epidemic of skin disease, accompanied with heavy mortality, which has attacked large numbers of the adult and aged inmates of two of the great London infirmaries. In Paddington Infirmery 163 of the inmates have been attacked, and 21 have died, showing a mortality of 13 per cent. In Marylebone Infirmery upward of 200 cases are said to have occurred and the mortality is there also considerable. The disease is not a new one in its main features; it is in its chief characteristics that which is generally known as general eczema. Its occurrence, however, in the epidemic form, its severity, attacking often the whole surface of the body, the facts indicating a contagious as well as an epidemic character; the large mortality to which it has given rise; its severe incidence amongst grown up and aged persons, leaving children, who are especially liable to eczema, almost scathless; its outbreak in the best built and most carefully supervised of the public Poor-law institutions; and the fewness of the cases simultaneously observed in private practice—all are circum-

stances of peculiar interest. There is at present no indication of what are the circumstances which have tended to invite the attack in these two pauper infirmaries, nor how it is that, while spreading simultaneously in Marylebone and Paddington, and to a slight extent only in Lambeth Workhouse Infirmary, it has not attacked Fulham or other district infirmaries in London.

The essential part of the disease is a universal dermatitis, accompanied usually by more or less exudation, and resulting in desquamation or exfoliation. It presents certain features linking it with eczema and pityriasis rubra, and yet has certain novel features. The eruption commences as a papular rash with some congestion of the skin around, sometimes on the face or arms and sometimes on the legs or trunk, and then it attacks other parts. Meanwhile the patches which have first appeared are maturing and going on to either vesication or desquamation without vesicles being evident. In about half the cases the whole body was involved. The skin lesion is the most evident feature, but it is accompanied in many instances by considerable constitutional disturbance. Thus, there is extreme weakness and prostration, and in nearly all cases great loss of appetite; the tongue is raw and denuded of its epithelium.

In many cases there is nausea and vomiting, and in others diarrhœa. The temperature in the earlier stages is not elevated; frequently it is subnormal, but when the skin lesion is considerable, there is generally slight elevation of the evening temperature. The disease runs a pretty definite course of some six or eight weeks' duration, but is very liable to recrudescences.

Dr. Sville describes two types of the disease—one a moist type, where there is considerable exudation, the other a dry type, where neither vesicles nor exudation are apparent.

#### LYSÆMIA OR MALARIAL HÆMATURIA.

Discussing this important disease-condition in the *New Orleans Med. and Sur. Jour.*, Dec. 1891, Dr. Martin says:

The aims of treatment in the order of their importance are:

1. To clear up the urine.
2. To evacuate the bowels and keep them acting that they may aid in freeing the system from the toxic agents set free by the explosion, and better the state of the system for absorption of remedies and nourishment.
3. To repair the damage done to blood and blood vessels.
4. To administer any anti-malarial remedy which will not interfere with carrying out the other indications.

The treatment itself may be tabulated under four corresponding headings:

1. The one remedy *par excellence* for clearing the urine is turpentine. I usually give an adult ten drops or a No. 1 capsule full every four hours, and have never failed to clear up the urine in from twelve to forty-eight hours. Improvement generally begins as soon as the odor of violets is noticeable.

The turpentine, in my opinion, acts not directly as a hemostatic, but as a reparative to the capillaries and as a diuretic.

I object to ergot or gallic acid for the reasons that, first, they can have but very little if any effect; second, if they have, it is bound to be a bad effect, as they have no diuretic action. The ergot might increase the pressure in the capillaries, and the gallic acid give a tendency to clot formation, both of which we wish to avoid. As for digitalis, I do not think it ever needed; the circulation is always oppressed and relatively slow, in some cases as low as sixty pulsations per minute—this from uremia; and if the digitalis has any effect toward

contracting the capillaries that would certainly increase the blood pressure in them and enhance the danger; and digitalis cannot have its usual diuretic action, for the kidneys are already engorged with blood.

Turpentine alone, given persistently as I have mentioned, will do all that one can wish toward carrying out the first indication.

2. The second indication may be accomplished by means of any purgative at hand. Calomel has no specific action; I give it in moderate doses in the beginning of the attack where vomiting is most severe, but prefer Epsom salts, and as a routine treatment prescribe a tablespoonful of the latter every four hours until six or more actions have been produced and then *pro-re nata*.

3. The third indication is met with nourishment and iron, preferably in the form of the tincture of the chloride. In a vitiated state of the stomach I do not believe that any other preparation of iron compares in utility with the old-fashioned tincture. I generally give a little nourishment, followed by from four to six drops of the tincture, well diluted, every four hours.

Suitable nourishment is generally difficult to obtain, for these cases occur mostly in the country away from markets and prepared foods. The most useful article in the largest number of cases in my hands has been buttermilk; it is always at hand in the country and is generally more relished by the patient than anything else obtainable. If a point is made with the patient and nurses that the iron is very necessary but will do harm on an empty stomach, there will be no more trouble about the nourishment of the patient.

4. The fourth or anti-malarial indication, I prefer to meet with arsenic—because it does no harm, and because, in the form of Fowler's solution it is palatable and readily retained; and further, because there is no hurry and we can well afford to await its slow but certain effect. Why not use quinine instead? I do not give it because quinine has killed every hæmaturic patient whom I have ever treated with it. I have known many patients to recover from this trouble who have been treated with quinine, but the weeks of illness, the many relapses and the months of convalescence show too clearly that the recovery took place not as the result of the quinine treatment, but in spite of it. The quinine must be eliminated; the kidneys have to do the work, and they are not in condition to bear the additional strain. The urine becomes more scanty, more viscid, more tarry; suppression and death rapidly supervene. If the patient has the constitution to withstand the diseased condition and the quinine too, he recovers, though very slowly.

#### ELECTRIC CATAPHORESIS FOR GOUT AND RHEUMATISM.

In an article upon this subject in the *Medical Herald*, Dec., 1891, Dr. de la Touche says:

The treatment which I propose for rheumatic and gouty manifestations in the joints depends upon two essential points:

1. The introduction of medicinal substances into the tissues through the cataphoric action of the galvanic current, in order to resolve the congestion and concretions.

2. The use of high intensities according to a particular method with a view of obtaining a tonic effect on the whole animal economy.

The medicinal substances are applied diluted, on sponges, preferably on linen or absorbent cotton. To the sponge is fastened a large ordinary electrode covered with chamois. The remedy must be placed on the positive pole, considering that the current passes from the positive to the negative pole. Morton advises to change both poles with the medicament. The physician can use iodide

of lithium, tincture of bryone, iodide of potassium, or other substances in small doses, according to the indications, for it is necessary, especially with high intensities, to avoid burns or erosions on the skin. These accidents cause the patient suffering and necessitate an interruption of the "sessions."

I apply large sponges of medium fineness, soaked in a medicated solution, on both sides of the knee (or of the ankle) for ten minutes, gradually going from a few milliamperes to 60, 80 and 100. The tolerance of the patient is the only means of judging. When I practice electrization on the lower limbs, I close the seance by uniting the two points of application of the right limb by a single wire and connect with the positive pole; the same is done on the left, and the wire joined to the negative pole. I then pass up the scale as far as the patient can endure and then gradually come down again. Almost at the same moment the patient feels hot waves passing through him (a kind of flow) which gradually rise from the ankle to the knee and to the pelvis, and, if produced with prudence, they give an indescribable sensation of "well-being" (*bien-etre*) which the patient himself calls attention to. The sensation is the only test in the use of high intensities and it is remarkable what an amount a person can endure, when the increase is slow and gradual and when the diseased surfaces are sufficiently protected by large electrodes. The same intensities would be impossible with electrodes of small dimensions; the operation would be painful, endurable only with difficulty and would cause rubefaction of the skin. Moreover, low intensities would be without the proper effect.

It is difficult to specify the number of sessions for the cure of a given case. As Trosseau says, a chronic disease requires a chronic treatment. Everything depends on the condition of the patient, the age of the disease and the general debility. In my mind, we ought to count on at least some twenty applications, sometimes even more. Moreover, in suitable cases the patient feels most usually, from the very first day, so decided a change that he will be ready to continue.

At first the sessions should be repeated daily. Later they should occur in longer intervals, in order to leave the patient for a longer time under their influence. With persons in whom electricity provokes excitement and insomnia (a rare occurrence) the sessions should be given in still longer intervals. Such sessions should last from fifteen to twenty-five minutes, according to the impressionability of the subject.

According to the advice of Beard and Rockwell, for ordinary electrization, strong persons can continue work immediately after the applications. Patients with a great deal of general debility, especially women, should avoid exercise after cataphoresis as described above.

Electric treatment should not be practiced in the acute stage; it is intended for chronic cases, although the beginning might be made in the subacute stage.

Gouty people are often afraid of the driving inward of the pain, of metastatic displacement. Therefore, the treatment should not be rash and precipitate, for any accident would be attributed to electricity. The best period, in my opinion, is the time when the patient is ready to leave his bed from an acute exacerbation with joints still painful and difficult in walking.

The immediate results are greater mobility of the joints. If we have to deal with the lower extremities greater ease of locomotion is observable. The patient feels lighter and more vigorous. The articulations become less painful. Often a patient, who has come to the office with a crutch, leaves it without such help. The effect becomes most pronounced ten or fifteen minutes after the application. **The improvement lasts from one-half to three hours and cannot be produced by**



any other means (massage, steam baths, douches, hot baths, mud baths.) It increases in proportion to the number of applications.

The consecutive effects are local and general. The concretions of urates in the tissues diminish; the pain disappears from the joint and the articulations acquire freedom of movement. The congestion and peri-articular swelling both tend to disappear.

Among the general effects the gradual regaining of strength becomes noticeable. The gait becomes less hesitating every day and can be continued for longer periods without fatigue. Vigor pervades the whole system. A workman told me that he could hold his hammer more firmly after the use of the current and that he could strike more forcibly on the anvil. The appetite increases and digestion is facilitated. The stools are more regular—in short, a general effect upon the nutrition of the whole body manifests itself, and sleep becomes quiet and refreshing.

#### PROGRESS OF INFLUENZA IN EUROPE.

The last number of the *Lancet* reports that the outbreak of influenza is spreading fast, with its customary concomitant of a highly increased mortality from respiratory affections. In the metropolis, for the week ending November 28th, thirteen deaths were attributed primarily to influenza, the total death-rate being 19.9 per 1000, or slightly less than the preceding week. It may be noted that the death-rate at Plymouth for the week ending November 28th, was 38.3, or precisely double what it was three weeks previously. There has also been a rise in the death-rates of Newcastle-on-Tyne and Sunderland. Influenza continues to be very prevalent in Scotland; it has appeared in a severe form at Sandy, one of the Isles of Orkney. In Glasgow it is said that it has never been so widespread and severe as at the present time; and almost the same is true of Edinburgh. In both places the resources of the profession have been severely taxed. Abroad the accounts are of like import. At Berlin it has been prevailing during the past month; it has been very severe at Hamburg and Dusseldorf, and is also spreading rapidly in the Silesian provinces and Schleswig-Holstein. It has appeared again in Paris, where Professor Brouardel has stated that it was responsible for 100 deaths during the past week. The Australian mails bring accounts of the deaths of several prominent Melbourne citizens from influenza, and it will be noticed that the New Zealand correspondent also speaks of its prevalence.

#### Medical Items.

A hospital for women has been opened at Sitka, Alaska, by Dr. Clarence Thwing. It is the first in that country.

The meeting of the Cuban Medical Congress, which was to have been held in January, 1892, has been postponed until the following October, when it will take place coincidentally with the quadri-centennial celebration of the discovery of America.

The committee of the British Medical Association on legislation for the inebriate, has reported in favor of endowing proper authorities with power to compel inebriates to be placed in retreats where they will be treated by physicians employing the most approved methods.

In Corea, physicians are only allowed to examine the patients in the following manner: A thread is tied around the patient's wrist and passed out by a hole in

the wall to the doctor outside, who, by inspecting the thread, is supposed to arrive at a diagnosis. Corean doctors are evidently gifted with what may be termed the "*tactus eruditus*."

The teaching of forensic medicine is said to be in a very unsatisfactory state in Italy. With the view of doing something to remedy this defect, the Italian Medico-Legal Society, a new association recently founded at Turin, is organizing a congress, which is to be held at Rome in September, 1892. Among the subjects proposed for discussion are: 1. The teaching of forensic medicine in the medical schools; 2. The establishment of similar courses in the universities.

A petition has been presented to the Tasmanian Parliament, signed by 5,730 women of Hobart, praying for improvements in the sanitary system of the town and soliciting support to the Metropolitan Drainage Area Bill. That is the kind of thing we should like to see at home here in the old country. If women can be got to combine in the cause of sanitation the battle would soon be won. *Ce que femme veut* she has a way of getting, and even Mrs. Lynn Linton could hardly see any objection to the members of her sex taking action in the cause of health, which is also, to a very large extent, the cause of human happiness.—*British Medical Journal*.

The periods of gestation are the same in the horse and ass, eleven months each; camel, twelve months; elephant, two years; lion, five months; buffalo, twelve months; cow, nine months; sheep, five months; reindeer, eight months; monkey, seven months; bear, six months; sow, four months; dog, nine weeks; cat, eight weeks; rabbit, four weeks; guinea pig, four weeks; wolf, ninety to ninety-five days. Goose sits thirty days; swans, forty-two days; hens, twenty-one days; ducks, twenty-eight days; pea-hens and turkeys, twenty-eight days; canaries, fourteen days, pigeons, fourteen days; parrots, forty days.

Father Mollinger, Pittsburg, who has been long posing as priest, thaumaturgist, prophet, and medicine-man, and who is said to have accumulated \$300,000 from his miraculous cures, is somewhat in disgrace. The inevitable nemesis which awaits chicanery has come. The blow comes from the source which more than any other sustained the reverend father's sensational pretensions—the lay press. The so-called cures have not been found. In excuse for Mollinger's practices it is pleaded that he is a regularly graduated practicing physician, and that he not only "lays on hands" but gives medicines. This, however, scarcely excuses the ceremonies of St. Anthony's day, when numberless poor and ignorant people were induced to sacrifice their property, and travel hundreds of miles for the relief of imaginary or incurable ailments.—*Physic. & Surg.*

The credulity of a gullible public, says the *British Med. Jour.*, has survived many shocks, so that it will not be much affected by the fact that a hypnotic performer, calling himself Dr. Vint, has been prosecuted at a police court in Wolverhampton for taking about with him as a part of his stock-in-trade, a number of men, whom he paid to simulate hypnotism, and drink nauseous draughts, and to tumble off the chair or platform at given moments, of course in such a manner as not to hurt themselves. An action brought by two similar paid assistants of another well-known stage hypnotizer was tried recently in the provinces, the two worthies having fallen out over the payment, and not finding themselves sufficiently remunerated for drinking petroleum and finding it as tolerable as champagne and for going through other tricks common in such performances.

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## CONTENTS

### ORIGINAL ARTICLES.

Occasional Hardness of Hearing Sometimes the Only Symptom of Post-Nasal Vegetations. By Hiram Woods, M. D., Baltimore. . . . . 177

Fractures and Injuries of the Spine in the Cervical Region. By De Forest Willard, M. D., Philadelphia. . . . . 180

The Suction Power of the Heart. By Edward Anderson, M. D., Rockville, Md. . . . . 184

### SOCIETY REPORTS.

Gynæcological and Obstetrical Society of Baltimore. November Meeting. A Parting Word upon Obstetrics. . . . . 185

### EDITORIAL.

The Influenza. . . . . 188  
The Pharmaceutical Agent. . . . . 189  
Sleep. . . . . 190

### MEDICAL PROGRESS.

For the Morphia Habit.—Progress of Influenza.—Free Education Act of England.—A Case of Physiological Albuminuria.—Management of the Paroxysmal Inebriate.—Ovariectomy; Its Use and Abuse.—Notes on Scarletina.—After-Treatment of Repair of Perineum.—Wounds of the Femoral Vein.—Treatment of Whooping Cough.—Typhoid Fever and Salads. . . . . 191

MEDICAL ITEMS. . . . . 197

## Original Articles.

### OCCASIONAL HARDNESS OF HEARING SOMETIMES THE ONLY SYMPTOM OF POST-NASAL VEGETATIONS.†

BY HIRAM WOODS, M. D.

Of Surgical Staff of the Presbyterian Eye, Ear and Throat Hospital; Professor of Diseases of the Eye and Ear at the Woman's Medical College, Baltimore.

The object of this paper is to call attention to a class of cases which are not uncommonly seen by the aurist and which should be always borne in mind, at least, by the physician. I have nothing to offer which is new to those who see much of aural troubles, but I am convinced from my hospital and office work that a paper upon the above theme will not be out of place.

The ear has a good deal of superfluous hearing power which it can lose before the individual becomes aware that there is any deafness. The most common test for hearing is the watch, and the distance at which a normal ear will hear the average watch is about 40 inches. One frequently sees a patient who complains of defective hearing dating back three or four weeks. Examination reveals asunken and dull-looking drum-head, with other evidences of advanced tympanic disease, while the hearing power for the watch is reduced to 10 or 12 inches. It is pretty certain that all this has not come about in three or four weeks. What has happened is this: for a long time slow changes have been progressing in the tympana or Eustachian tubes, with a gradual lessening of the hearing power. When this disease has reached a certain point it becomes perceptible to the in-

†Read at the 732nd meeting of the Medical and Surgical Society of Baltimore, Nov. 10th, 1891.

dividual or his associates and from this time the deafness is dated. Enquiry elicits a history of occasional tinnitus aurium, difficulty in following general conversation, and other symptoms which made little or no impression at the time. There is probably, too, a history of some old throat trouble; and chronic changes are found in the faucial mucous membrane. Treatment in these cases of chronic dry aural catarrh is usually very unsatisfactory. Nor is it always easy to give a definite prognosis. One is frequently surprised by improvement in a bad case as well as by failure with a more promising patient. As a general rule, the less marked the changes in the tympana and tubes, and the more curable the pharyngeal lesions, the better the prognosis. Thus, important factors are the time and degree of deafness; the improvement or lack of it, in hearing after Politzerization, or the use of the catheter; the hearing of the tuning fork better by aerial or bone conduction, as indicating whether or not the acoustic nerve has been involved; and the previous treatment. But, after all, most patients get little permanent help. Therapeutic measures should be employed before secondary changes have taken place in the middle ear. At this time, however, the aural symptoms are apt to be unnoticed, as they are usually not pronounced.

Under the name "Sub-acute Aural Catarrh" Roosa (*Diseases of the Ear*), describes a class of cases seen usually in children. The symptoms are more or less hardness of hearing, sometimes more than at others, a dull drum-head with obliterated light spot, showing that the membrane is drawn in, more or less mucopurulent secretion in the naso-pharynx, and improvement in hearing after inflation by Politzer's method. The aural disturbances are frequently only functional. If the throat troubles be cured and Politzerization continued for a time the hearing power returns to normal. If the case be neglected, either acute inflammation develops in the tympanum or, more commonly, the slow changes leading to chronic aural catarrh are set up. Such symptoms as Roosa here describes I have frequently seen associated with post-nasal vegetations, which also impaired or destroyed nasal respiration. Possibly the growths were the starting point, producing the hypersecretion in the naso-pharynx and post-nasal pharyngitis, which, in its turn, caused Eustachian catarrh. The resemblance of these cases to those which I desire here to emphasize is confined, however, to the impairment of hearing removable by Politzerization. The points of difference are the constant impairment in one class, the transient deafness in the other; the marked symptoms of pharyngeal disease in the one, their almost total absence in the other.

CASE I.—Miss W., 16 years old, came under my care at my office in the winter of 1889 for "occasional attacks of bad hearing, usually in damp weather." At the first visit she heard conversation easily at fifteen feet, while the watch was heard at 30 inches. This was practically normal hearing. The external meatus revealed nothing. Drum-head clear. Both tympana could be inflated with the Politzer air bag. There was good nasal respiration. In the pharyngeal vaults I could feel a number of adenoids, but, as they did not cause mouth breathing, I did not remove them. The growths were found not only in the vaults, but along the posterior wall of the pharynx. At subsequent examinations I found hearing somewhat defective for conversation, while for the watch it was at times as low as five or six inches. Tinnitus was present now and then when hearing was defective. After several months observation, I noticed a slight nasal twang in the voice at times, although nasal respiration was still good as a rule. In damp weather it was somewhat impeded. I now cleaned out the naso-pharynx

with Mackenzie's forceps. Not to prolong the case—hearing soon became normal and the attacks of hardness of hearing ceased. I have had several opportunities of examining this patient, and while even now her throat sometimes annoys her, her hearing has remained good.

CASE II.—R. N., 13 years old, consulted me at my office in October last for occasional attacks of hardness of hearing. His mother said that frequently remarks would have to be repeated to him, although he was evidently paying strict attention. Hearing was worse in damp weather. My watch, which should be heard at 48 inches, was heard at 24. Conversation in an ordinary tone could be carried on at six feet. The right canal was partly closed by wax, but its removal did no good. The drum-heads were lustreless, light spots dim. Both middle ears could be inflated by either the Valsalvian experiment or by Politzerization. Nasal respiration was good and had never been impaired. The posterior wall of the naso-pharynx was covered with vegetations, and they were also found in the vault. The nasal septum was deviated toward the right, but not enough so to embarrass respiration in this nostril. Occasionally a watery discharge from the nose had been noticed, which had led him to undergo treatment elsewhere for catarrh. This treatment, as I gathered from the boy, was mainly directed to the pharynx. If the vegetations were recognized, their removal was not thought necessary. I advised operation, and performed it at once. The following day I again introduced the forceps and removed two or three growths which had escaped me the day previous. An alcohol spray was used for a few days, when my watch was heard at 48 inches. It is too soon to speak positively of this case; but the child was in my office two weeks ago—a month after the operation. He still has normal hearing, and has had no attack of ‘hard hearing’ since October.

Woakes (*Post-Nasal Catarrh*), discussing the effects of post-nasal vegetations upon the hearing apparatus, states that “when the vegetations affect mainly the vault,” and “catarrh is the prominent symptom of the throat affection, the tendency is for this to involve the Eustachian tubes and tympanic cavities. Suppuration and, in short, all the accompaniments of confirmed otorrhœa, are most frequently seen under these circumstances.” Again: “an extensive development in the *vault* of the pharynx interferes less with the function of the Eustachian tubes than does a *much smaller amount* seated upon the *posterior wall*. In this latter situation, a *single growth* will induce hypertrophic catarrh of the pharynx extending into the tubes, and especially the formation of redundant folds of tissue about their orifices.” (The italics are my own.)

These are just the conditions leading to closure of the pharyngeal openings of the Eustachian tubes with subsequent absorption of the air in the drum cavities, sinking in of the membrane, and the train of pathological changes leading to chronic adhesive aural catarrh. The temporary nature of the deafness in the two cases narrated was probably due to the fact that the hypertrophic process had not progressed far enough to cause permanent closure. The occurrence of hard-hearing in damp weather was insisted upon by both of these patients. This symptom is, I think, a very common one among persons suffering from throat deafness. I suppose it is due to a temporary swelling of the tissues about the Eustachian orifices, already in an irritated and hyperæmic condition.

In conclusion, I would lay stress upon the following propositions:

I. No defect in hearing, however slight or transient, should pass unnoticed. Such attacks mean that something is wrong, and this something should be promptly discovered, and, if possible, removed.

II. The aural complications of post-nasal vegetations are not always dependent upon obstructed nasal respiration.

III. These growths may exist and do harm, before mouth-breathing, snoring and alterations in the facial expression, the symptoms usually relied upon for a diagnosis, lead one to suspect their presence.

525 N. Howard St.

### FRACTURES AND INJURIES OF THE SPINE IN THE CERVICAL REGION.†

FRACTURE OF THE THIRD VERTEBRA—CERVICAL SPINAL HÆMORRHAGE—FRACTURE  
OF ODONTOID—FRACTURE OF FOURTH VERTEBRA.

BY DE FOREST WILLARD, M. D.,

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Philadelphia.

The following group of injuries to the spine, taken in connection with the cases of laminectomy reported by me in the *Transactions of the College of Physicians*, Philadelphia, January, 1890, and February, 1891, show that the prognosis in the majority of the cases of injury to the spine is determined almost entirely by the initial lesions—*i. e.*, the amount of injury which has been primarily inflicted upon the cord. In nearly all cases of spinal fracture the substance of the cord receives severe contusions or lacerations, and the resultant symptoms are not only dangerous, but it frequently happens that death ensues in a short time.

The first case shows that even very positive bone injury in the cervical region may produce symptoms of but moderate severity, provided the cord is uninjured.

*Fracture of Third Cervical Vertebra.*—E. R., male, aged thirteen years, fell through an elevator shaft some thirty feet. He was picked up unconscious and removed to the hospital. Upon examination a large hæmatoma was discovered over the occiput, but there were no external evidences of injury. The head was retracted and turned markedly backward; it could be bent only slightly from side to side. Rotation was possible only to a slight degree. A finger passed into the mouth discovered a distinct prominence behind the posterior wall of the pharynx corresponding to the third cervical vertebra. The rigidity of the neck muscles was great. There was no paralysis, no cough, no loss of sensation, nor could crepitus be discovered. There were no evidences of severe pressure upon the cord. Flexion, extension and rotation were almost impossible.

Under strong extension and counter-extension applied upward from the head and downward from the body the deformity was markedly reduced. A plaster-of-Paris collar applied while extension was maintained was accurately fitted, so as to keep the head in a fixed position. This bandage was arranged so as to press on the occiput as high as the prominence, also to press upon the mastoid and temporal bones, and to curve forward so as to encircle the lower jaw. It then accurately fitted the neck from whence it extended to the shoulders and passed down loosely to envelop the upper part of the thorax. This maintained the head accurately in position and prevented any movement of the upper portion of the trunk, neck, or head. This was applied in place of extension and counter-extension on account of the sensitive condition of the hæmatoma over the occiput. After the tenderness from the blood tumor had disappeared, weight and pulley extension were applied to the head and feet up to the point

†Read before the Philadelphia County Medical Society, December 9th, 1891.

of comfortable endurance. The plaster envelopment was sawed open and permitted to remain as a splint to prevent lateral rotation and flexion.

He was kept in this position for six weeks. There was no impairment of motion or sensation during this time. The extension apparatus was then removed and an accurately fitted neck splint of plaster-of-Paris was applied. He wore this with comfort six weeks longer. At the end of this time examination of the pharynx showed that while there was still a slight prominence in the posterior part of his throat, the deformity was much less evident than at the time of the injury. There was less rigidity, but no deviation of the vertebral column could be discovered. The absence of pressure-symptoms resulting from the injury was a point of special interest. A year later he could move his head in all directions, although motion of the chin to the right was limited. Flexion seemed perfect. It is but seldom that a patient either breaks or dislocates his neck without more serious symptoms.

*Cervical Spinal Haemorrhage.*—W. M., aged eighteen years, was injured by diving eighteen feet into a pool of water two feet deep. He struck his back and the back of his head on the bottom of the pool. He was immediately pulled out by his comrades and was found to be unconscious. He remained in this state two hours. When first seen, some time later, he was blanched and pale, and complained of a pain in the back of his neck and beneath the shoulders. Sensibility was present throughout body and legs, but apparently diminished. There was no opisthotonos, and no rigidity of the neck other than that motion gave slight pain. There was no tenderness over the region of the spinal cord, except slight pain in the lower cervical region. There was no visible displacement of the vertebræ, and no positive evidence of dislocation or fracture. Flexion extension and rotation of the head were perfect and accompanied only with slight pain. The spinal column could be flexed and extended normally. Motion and extension in both arms, body and legs seemed in good condition, except as regards the sensibility as above noted.

He was partially conscious and could answer questions intelligibly, but with an apparent effort of the will, and his speech was slow. There was anæsthesia of both hands, especially on the ulnar side. He complained of pain in the region indicated. There was constant and decided priapism.

This condition continued until about seven hours after the accident, when he slowly seemed to lose power of the hands and forearms on both sides, commencing apparently in the region supplied by the ulnar nerve. Also there was progressive loss of sensation in both hands and forearms. Both brachial plexuses were sensitive to the touch, but not painful. Priapism still continued, but the urine was voided naturally. The scrotum was anæsthetic and remained so for several days, and uncertain areas of the abdomen seemed in the same condition, but his answers to questions were not very satisfactory. The legs retained both motion and sensation although both functions were apparently diminished.

The patient seemed to rouse from his unconsciousness at the end of the first hour and was moderately intelligent.

Up to this time extension made upon the spinal column by means of the head gave relief from pain, therefore an extension and counter-extension apparatus was applied to the head and extremities, and continued traction was maintained.

Loss of motion and sensation increased during the next twenty-four hours until the patient was able only to move his arms feebly; fingers immovable. Sensation was entirely absent in both hands in the region supplied by the ulnar nerve. Sensation was impaired in other regions of the forearm and hands.

During the next two days there was apparently no change either as regards motion or sensation, but on the following day both functions began slowly to return.

At the end of the fifth day he could raise his arms, but only for a moment. When the extensor muscles were required to fulfill their functions the arm immediately fell. There was still a tendency to priapism, but the condition was not constant; the scrotum was still anæsthetic. Temperature, pulse and respiration remained unaltered.

Continuous extension was maintained, and as there was no paralysis it was deemed probable that all hæmorrhage within the canal had ceased.

Motion and sensation returned to a slight degree in the thumb and fingers of the hand and in the arm, until gradually both functions were restored almost entirely. The scrotum remained anæsthetic for ten days.

Fifteen days later he could grasp an object with considerable firmness.

A trapeze was rigged over the bed so as to exercise the arms while extension was being maintained. An ischio-rectal abscess discharged for two weeks and then healed.

In eight weeks had thoroughly recovered and presented no abnormal symptoms. Motion and sensation complete.

A peculiar condition regarding this case was that after the condition of shock had passed away there were no serious symptoms until the probable occurrence of hæmorrhage had begun to make pressure upon the spinal cord and thus to interfere with its functions. The occurrence of paralysis upon both sides instead of upon one, and the length of time after the injury, showed that the symptoms must have been largely due to gradual compression.

*Fracture of the Odontoid Process of Axis with Dislocation of Atlas.*—C., aged eighteen years, fell twenty feet, striking upon his head. He was picked up stunned, but soon regained consciousness. He was able to walk to his home, several squares distant, and to talk with his friends. An hour and a half later he was perfectly rational, talked freely and pleasantly, and complained of no pain when at rest; he simply desired to be permitted to sleep. He was quiet, but would suddenly start with an anxious look. The trunk and extremities were cold; pulse 85, feeble. Pupils equal, but failed to respond readily to light. The head was thrown backward with the occiput to the right, but he complained of no pain. The chin protruded, and the thyroid gland was prominent. Any movement or rotation of the head toward the right was accompanied with pain. Motion to the left was painless for a quarter of a circle, but any greater motion caused discomfort. There was no contusion or laceration of any part of the body; no depression of the skull, nor any evidences of fracture of the cranium. Pressure over the cervical region gave severe pain. The spinous processes of the cervical vertebræ were in line up to the third, but above this was a marked depression, while a little higher the position of the atlas was slightly projecting to the right of the median line. Manipulation caused so much pain that ocular examination of the pharynx could not be made. Digital examination revealed a slight prominence of the second vertebral body.

*Diagnosis.*—Dislocation of the axis from the atlas; probable fracture of odontoid.

During the night he slept at intervals, but roused at the slightest noise. There was no pain, except upon movement of the head.

In the morning he took nourishment, and complained of no suffering. He ate a light breakfast, and was anxious to go to his business. Three hours later he



began to grow drowsy, and in two hours became semi-unconscious, but could still be roused. He answered questions intelligently, but closed his eyes as soon as he had ceased speaking. The tongue was protruded straight from the mouth, and with difficulty; the pupils responded to light; the right eye was a little more responsive than the left. There was no paralysis, except of the bladder, the urine not having been passed since the accident. The catheter secured eight ounces of apparently normal urine. Pulse was 80, full; respiration 16, deep but not snoring.

Twenty hours after the injury the pulse was 48; respiration 12, somewhat stertorous, not puffy or blowing. Could be roused only with effort. Answered unintelligibly; occasionally, however, an articular word escaped. He constantly pulled at the bedclothes. The urine dribbled. Pupils were nearly the same size, but the left responded more readily to the light. At the junction of the forehead with the hair, for an inch and a half to the left of the median line, apparently the point where the head came in contact with the ground in the fall, the scalp was œdematous and there was a slight depression. Pressure upon several points in the same region gave similar pitting. No evidence of fracture.

No injury could be discovered in any portion of the body save the neck.

There was no paralysis of any portion of the body, but there was slight impairment of motion of the right arm and leg. The head could be moved with little more freedom toward the left, but a slight force caused the patient to cry out and to steady his head with his left hand. There was rather less deformity than at first at the back of the neck; the thyroid was not so prominent. Liquid food was taken without difficulty. He passed a restless night, constantly pulling at the bedclothes, tossing about on his couch, and muttering in delirium.

Forty hours after the injury it was noticed that he moved the right arm and leg less frequently, although both members could still be brought into use by a special effort of will. Pupils as the day before; respiration also; pulse 60. The patient responded to loud shouting, but could give no intelligible answers. although frequent attempts at utterance were made. The urine dribbled constantly.

Seventy-two hours after the accident the pulse was 100; respiration 20. Increased loss of power, but members still capable of being moved.

Eighty-four hours after the injury the pulse was 130, feeble; respiration 24. Delirium less violent. Patient remained quiet, except when partially awakened. When roused by any cause the left hand still pulled the bedclothes. The right arm and leg were still capable of being moved slightly, but the muscular power was weakened. Unconsciousness increased with total inability to speak. Bowels not moved since the accident. Pupils normal in size, still contracting under the influence of light. Liquid nourishment had been swallowed up to this time, but was now refused. Died quietly ninety-eight hours after the injury.

*Post-mortem:* Examination of the neck alone was permitted. The posterior cervical muscles were filled with extravasated blood from the occiput to the fourth vertebra. The spinous prominence of the atlas lay to the right of that of the axis and on a plane posterior to it, causing the axis to appear as though it had been pushed forward. In reality, however, its position in relation to the third vertebra was normal—the atlas being the dislocated bone. The left inferior articular process lay behind the articular process of the axis, while the right inferior articular process of the atlas lay anteriorly. This displacement was permitted by a fracture of the odontoid process of the axis. One fracture extended directly across its base; while the other had broken off a small portion of the anterior

surface—the line of the fracture being almost at right angles to the first. The odontoid process, however, was still held in position by the transverse odontoid ligature, which was unruptured. As noticed during life, the atlas could not be rotated to the right, while it could be turned to the left. Strong extension made upon the atlas permitted it with difficulty to be brought into position.

*Fracture of the Third, Fourth and Fifth Laminae; Death.*—W. P., aged forty years, fell from a scaffolding, a distance of twenty feet, striking the top of his head on a curb, and alighting as nearly as possible with the axis of his body in a straight line. When seen half an hour later he was suffering from shock. His pulse was 80, and his respiration feeble. He was perfectly conscious but indifferent to surroundings. There was a large, lacerated wound of the scalp four inches in length transversely across the forehead. In the region of the third and fourth vertebræ there was marked displacement forward of the third with prominence backward of the fourth dorsal spine. There was total paralysis of both motion and sensation, and of all parts of the body below the portion supplied by the corresponding nerves. Neither urine nor feces had been passed since the accident. There was no priapism. Extension and counter-extension had no effect on the deformity.

The patient rallied for two hours, the pulse reaching 110 and the temperature 100°. He complained a great deal of pain in the back of his neck and shoulders. Soon after the respiration became more hurried, the heart's action much more feeble, and although perfectly conscious for one or two hours, he soon sank into a state of drowsiness, and died ten hours later.

At the autopsy there was found a fracture of the body of the fourth dorsal, with fracture of the laminae of the third, fourth and fifth. The third was greatly displaced forward, carrying with it a fragment of the fourth. The cord was entirely torn across at the junction of the third with the fourth, and was pulpified for half an inch and compressed by the fragments of the other laminae.

Laminæctomy would have relieved pressure, but would not have restored the crushed and torn cord.

### THE SUCTION POWER OF THE HEART.

BY EDWARD ANDERSON, M. D., OF ROCKVILLE, MD.

I have seen several patients in the last year or two who, though threatened with apoplexy for a long time, never had an attack until the heart lost its force and became irregular in action, thereby losing its power to draw venous blood from the head. Too feeble heart action predisposes to apoplexy, as strongly as too forcible action of that organ. Alcohol and digitalis are clearly indicated in these cases.

During our late enfeebling epidemic I saw a man, thirty-four years old, in an apoplectic fit, who had been bled profusely. He grew worse much more rapidly after the bleeding, and as I thought, in consequence of it, died in a few hours. I opine that very many deaths attributed to heart-failure are really due to apoplexy.

### SPASM OF THE GLOTTIS.

Sir Morrell Mackenzie finds that by exciting a rival reflex the laryngeal spasm is at once overcome. By exciting a paroxysm of sneezing, immediate relief is procured. This is best done by the inhalation of a pinch of snuff into the nares; or pepper may be used in the same way. It is sometimes possible to produce sneezing by tickling the nasal mucous membrane.—*Med. and Surg. Rep.*

Society Reports.

## GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

NOVEMBER MEETING.

The President, Dr. William E. Moseley, in the chair.

*Dr. John Morris* gave an address entitled A PARTING WORD UPON OBSTETRICS: I began the practice of obstetrics forty-six years ago, and for the first four years kept a record of my cases. The first year I attended 35 cases. I was associated with Dr. Hintze, who at that time had a very extensive general practice and who was very often called to assist midwives in their troublesome cases. I kept a careful record of my first 200 cases, but after that I abandoned the record—a fact which I have since very much regretted.

My first case was a very unfortunate one. I attended the patient in my student days. This woman was in the country and was in labor three days. At the end of that time I sent for Dr. Hintze, who delivered her with the crochet.

On account of the long impaction of the head the whole of the anterior wall of the vagina sloughed away. The woman is still living, but so much tissue was destroyed that it was quite impossible to close up the opening, and all these years the urine has been passing from her as rapidly as secreted.

My second case was a black woman who had a prolonged labor. I had never seen the forceps used, but tried to put them on and failed. After a while the child was born without any artificial assistance.

One of my greatest difficulties in my first cases was to find the cervix. I had never had any practical instruction in obstetrics, and did not know that in the first stage, before much dilatation, the os is usually found far back against the sacrum.

Among other things that I think I have learned is how to shorten labor. One of the best means of accomplishing this is by external pressure. I learned that from my master, Dr. Hintze. Another was to pass the cervix around the occiput; and I found that these two shortened labor very considerably.

I think I acquired the art of preserving the perineum. I believed in keeping the head under control, and not allowing it to be delivered too rapidly. In Ireland I learned how to preserve the perineum when using forceps. The secret is simply to change the axis of traction as the head comes to the perineum, first upwards perpendicular to the bed, and then carrying the handles over on to the abdomen of the mother.

I have found that midwifery is under-rated in the profession; but I am convinced that in no branch is there greater opportunity to display skill and judgment. This branch is esteemed much more highly than formerly.

Formerly in conditions of rigid cervix it was the practice to bleed. I have done it many times, but it would not be tolerated now. I am convinced that hot water injections will assist in relaxation. I have no faith in belladonna.

I have been fortunate in not seeing any cases of hæmorrhage. I believe external pressure used during labor will prevent post-partum hæmorrhage.

For the first ten years I used ergot in nearly every case during the second stage, but have not used it now for fifteen years. In case of delayed labor I now prefer the forceps to ergot.

The crotchet has gone out of use, but formerly it was used frequently. Often the woman was injured and not infrequently the doctor's fingers suffered. Dr. Hintze had a glove to protect his fingers.

We had at that time no chloroform, and often in transverse positions the woman would die undelivered because it was not possible to turn and deliver. I have not habitually used anæsthetics except in forceps cases. I have thought that they prolonged labor, but I always use chloroform when any force is to be resorted to.

I have never used the binder, because I could never see the philosophy of it. It will not stay in position and it is absurd to think that it controls hæmorrhage. The only good that I could ever see that it accomplished was to please the woman. When to use forceps: Always use forceps when labor is delayed in the second stage. The old forceps were a much weaker instrument than the ones constructed on the Tarnier principle. I think the Tarnier forceps the greatest advance in obstetrics in my time.

In placenta previa, and in abortion, we formerly used a tampon made of a handkerchief, rags, cotton or anything that could be had. These tampons were dirty and dangerous. Later I have used only the colpeurynter. It assists to dilate the os, as well as being the most efficient tampon. It is clean and harmless. Opium is the best thing to relieve pain in labor. It does not arrest the labor. When the os is dilated it increases the contractions.

*Dr. F. E. Chatard* exhibited to the society obstetrical instruments used by his grandfather, 1810-1840, and also those used by his father, 1835-1875. He stated that he had used external pressure with apparent good effect.

*Dr. Wilmer Brinton* stated that external pressure was used by primitive people. He thought that in rigid os he had gotten good results from the administration of chloral in fifteen grain doses every fifteen minutes until three doses were given, as recommended by Playfair. But the number of cases in which he had given chloral was small.

*Dr. G. Lane Taneyhill* had used chloral per anum with great satisfaction in three cases. In less than an hour the os had been considerably dilated, and delivery was effected in each case within three hours, other remedies having failed. He learned this treatment from our learned fellow-member, *Dr. Williams*—he uses 30 grs. chloral in milk.

*Dr. P. C. Williams* thought it was very important to consider agents to relax the parts. Chloral in 40 to 60 grain doses per anum had given good results, but sometimes it, as well as chloroform, fails to completely relax the cervix.

In his earlier experience he had encountered many cases of post-partum hæmorrhage, but since he had made use of a practice that is condemned by most obstetricians, that of giving ergot before chloroform, he had not had a single case of hæmorrhage. He had seen no harm result from this practice, but thought he had in this way shortened the labor.

The objection to morphine to relieve pain is that it nauseates badly afterwards. Chloral must be pushed to get good effects. The objection to it is that sometimes it leaves the patient more or less delirious, and may seriously depress the heart, if given too frequently.

*Dr. William S. Gardner* had used chloral in fifteen grain doses repeated every fifteen minutes in a series of cases, and found that while the patients had very little relief from pain, a large percentage of them would be made sick at the stomach, and the discomfort caused by the disagreeable taste of the drug and by the vomiting following its use, more than counter-balanced the little good it did, and its use in this way was abandoned. He gives it frequently for the relief of false labor pains. A dose of thirty grains will almost invariably relieve the pains and put the woman to sleep.

*Dr. Wm. P. Chunn* had used chloral a number of times but could get no positive evidence of its value; but it does not seem to obtund the pain. If opium will do this it might be advisable to use it.

*Dr. L. E. Neale* was surprised that a discussion as to the value of chloral should be brought up. He thought that the time for the discussion of that subject had passed. Whether it would act more efficiently by the rectum or by the stomach he did not know, but he thought 60 grains too large a dose and would be afraid to use that much as an ordinary dose by the mouth.

The remarks were entirely too general to admit of special discussion.

712 N. Howard St.

WILLIAM S. GARDNER, M. D., Secretary.

HERPES ZOSTER IN CHILDREN.

A correspondent of the *Lancet* writes:

In a communication read to the Société Médicale des Hôpitaux on November 20th, M. Comby once more drew attention to the trifling inconvenience incurred by children affected with herpes zoster as compared with the suffering sometimes caused by the same tropho-neurosis in old people. During a service of eight years at the Children's Dispensary in the district of La Villeffe, M. Comby has been enabled to collect notes of thirty-three cases, including twelve in boys and twenty-one in girls. This predominance of the female element has already been remarked by others, notably M. Descroizilles, of the Hôpital des Enfants Malades. Of these thirty-three children, four only were under two years, seven were ten years old, the youngest was aged eight months, and the oldest fifteen years. M. Comby states that above the age of two years zona is as frequently met with in children as in adults. He has never witnessed any epidemic of the disease, but a traumatic origin could be traced in two of his cases. In one, the bite of a horse preceded by three weeks the appearance of brachial zona; in the other, vaccination performed eight days previously seemed to have been the starting point. The symptoms of infantile zona are purely objective, the disease being constituted by the vesicular eruption only. In children above ten years, however, mild neuralgic pains may be complained of, but this neuralgia is ephemeral. A slight febrile movement—the zosterian fever of Landouzy—together with a loaded tongue and foul breath, may occasionally be present; but this is quite exceptional. The consecutive anæmia and emaciation noted by Descroizilles was never observed by M. Comby. Is zona a microbic affection? Its non-recurrence certainly pleads in favor of that theory; but the traumatic cases cited above render the acceptance of such a view of its pathogeny difficult. Besides, the protection conferred by a first attack is not so absolute as many would have us believe; for although Mr. Hutchinson only made out one instance of recurrence in 100 cases, Dr. Pye Smith has seen four examples out of the same total. For the present we must perforce accept Professor Bonchard's dictum that zona is a manifestation of neuritis, which neuritis may be specific, but which may also be of traumatic or other origin.

ANÆMIA OF GIRLS. (SIR ANDREW CLARKE.)

R.—Ferri sulph. . . . . gr. xxiv  
 Magnesiæ sulph. . . . . 3 vj  
 Acid sulph. arom. . . . . f 3 j  
 Tinct. zingiberis . . . . . f ʒ ij  
 Inf. gent co. *vel.* . . . .  
 Inf. quassiæ . . . . . f ʒ viij

M. Sig. A wineglassful twice daily, about eleven and six.

**THE MARYLAND MEDICAL JOURNAL.**

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BALTIMORE, DECEMBER 26, 1891.

**Editorial.****THE INFLUENZA.**

The reports of practitioners from all parts of the city inform us that the epidemic of influenza has returned for the third successive winter. As in past years, it has not entered upon its course in all sections at once; at least not with like intensity, certain practitioners being fully occupied with it before it has entered the practice of others.

In some parts of the world it seems to be adding largely to the mortality. In Baltimore it has, so far, been milder than in preceding years. A certain number of old and very feeble persons have succumbed to its depressing influences, but young and previously robust persons have either fought it off without the use of drugs, or convalesced rapidly under proper medical treatment.

We cannot say that the disease has varied to any degree in its type since its last appearance. It is essentially an inflammation of the respiratory passages, associated with an intense depression of the nervous centres, and sometimes more or less disorder of the digestive secretions.

The treatment of the disease in favor at the present time differs somewhat from that used in former years. Antipyrin, which was so extensively prescribed by many physicians for the nervous aches and pains, is now in disfavor. Its place seems to have been taken by antifebrin, which is now also on the wane, and phenacetin. The salicylate of quinine holds its own as a remedy for the aching in the limbs and body. Quinine seems valuable as a preventive of the disease or as a remedy in the very earliest stages, but it does not relieve the pains of a fully developed attack.

The headache is often relieved by the bromides, which then secure much-needed rest.

Calomel stands among the foremost remedies for the disease. In large doses of 3 to 5 grains in the first days of the attack, it opens the bowels, corrects the disordered secretions of the digestive canal, and improves the appetite. It also in most cases relieves the headache. When the bowels have been freely moved before the physician is called, by other aperient remedies, doses of  $\frac{1}{2}$  grain calomel quiet the stomach and often relieve the headache. Salivation is, perhaps, more easily induced in influenza patients than in others. It is said that codeine sulphate, for many years a trusted agent with the editor, is coming into favor this winter for the aches of influenza, but it seems to be decidedly inferior in this respect to the drugs above mentioned.

The respiratory inflammations of influenza are generally benefited by carbonate of ammonium in syrup; and codeine sulphate added to this will usually relieve the soreness and "rawness" and aching associated with the act of breathing, and sometimes produce sleep. The tendency in prescription seems to be to avoid all drugs which depress the heart. When the passage of very offensive stools suggests that the bowels are full of decomposing matter, which is poisoning the blood, castor oil may be used with great benefit, clearing away this foul matter very efficiently.

The severest forms of respiratory and nervous disease, as shown in pneumonia and in delirium or convulsions, have not been frequent this winter.

The danger of heart failure should lead all persons affected with influenza to take life easy for the next few months.

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#### THE PHARMACEUTICAL AGENT.

The drug-sample man is about again in full force. With artful guile he seeks the ear of the busy physician.

Now he forces his way through the reluctant office door, sinks into an easy chair and proceeds at once, without delay for common civilities, to an elaborate and rapid oration on most intricate procedures gone through with in the evolution of his sample, which as yet reposes in the recesses of his hand-valise. And he seems so hurt, almost offended, when the bewildered doctor breaks in at one of the closely-articulated joints of his dissertation (how the man can ever remember it all is a mystery), with the request for a written copy which he may study out at his leisure.

Sometimes he appears with a whole satchel-full of proprietary drugs of complicated formula, endorsed by hosts of eminent physicians. These repose upon the doctor's mantel-piece until a hypochondriac patient comes along and absorbs them all, saving the trouble of writing prescriptions and clearing a space for the next man's samples.

There is, however, a class of agents whom we are always glad to see, even when we are busy. These are the agents of manufacturers who are attempting either to introduce new therapeutic remedies to the profession, or to make im-

provements in well-known preparations of familiar drugs, or who present some new mechanical appliance for the sick-room or the surgery.

The physician may be brief with them without being guilty of rudeness. The drug-agent, who is often a physician who has been brought into pecuniary straits or who has fallen into ill-health, will usually respond quickly to the statement that time is precious, and will always be ready, to do a kind turn in the way of securing additional information or forwarding additional samples to one who treats him politely.

We should never forget the great debt which practitioners owe to the activity of Pharmacy, which has a right to an honored place in the great family of the Medical Sciences.

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### SLEEP.

The waste of substance which is manifested by the overworked nerve-cell (as explained in a recent article in our column by Dr. Preston on the Rest-Cure), demands attention from the practitioner. Dr. Preston has clearly explained the manner in which the replacement of this lost substance may be secured by physical rest.

The editor would ask the attention of the reader for a moment to the importance of mental rest in sleep.

Individuals are variously affected by loss of sleep. Some persons can be comfortable and do their daily work with very little sleep. The names of many great men of the past are cited as illustrations of this fact.

Other persons suffer greatly from loss of sleep. Those who manifest their need of sleep by becoming sleepy require no special consideration here, as they protect themselves by going to sleep wherever they may happen to be and without regard to their company. But there are certain individuals who, when they are suffering from lack of sleep, do not recognize their need of it, because they do not feel sleepy. They simply feel dull or miserable, and suppose that some strange disease influence or moral degeneration is working upon them. Headaches and neuralgias may frequently be traced to this cause by the wise physician. In the invalid, the mental fatigue which is due to loss of sleep often manifests its presence by restlessness, insomnia, and even delirium. The highest diagnostic skill is necessary for the detection of the cause in such cases; and unless the physician intentionally or accidentally induces prolonged and restful sleep, the patient will not recover from the obscure disorders of which he complains.

We have for some time made it an important aim in our treatment, in all obscure cases, to inquire very closely into the habits of the patient as regards sleep, and to secure early, restful and continuous sleep throughout the night. One night of restless tossing will do more harm to the patient than many days of discomfort. Therefore, get sleep; by all means which are not otherwise harmful. One or two forty or sixty grain doses at night of bromide of sodium or potassium



will shorten many a troublesome or dangerous illness. For children or the aged, somewhat less doses are required; but to be efficient in producing sleep the bromides must be given in as large doses as possible, and not in small repeated doses.

The benefit of the rest-cure and of travel to the chronic invalid is probably due in some degree to the opportunity and ability for sleep secured by these agencies.

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### Medical Progress.

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#### FOR THE MORPHIA HABIT.

The *Northwestern Lancet* quotes from the *Journal of Inebriety* the statement that M. Ball and Dr. Oscar Jennings, after considerable experience in severe cases, have found the best course of treatment for tiding over the difficulties of the time of compulsory abandonment of morphine is by hypodermic injection of sulphate of sparteine in doses of one-sixth to one-third of a grain. This acts as an immediate cardiac stimulant. They do not find sudden and complete suppression of the use of morphine in such cases always advisable, but give some occasionally in dangerous collapse. They testify also to the usefulness of a few drops of a solution of nitro-glycerine put on the tongue as giving momentary relief in moments of crisis.

#### PROGRESS OF INFLUENZA.

Influenza appears to be spreading rapidly in France; it is especially prevalent in the south-west, but has made its appearance in Paris. The Assistance Publique are making preparations to deal with a large number of cases should this be needful, and the tents used in 1889-90 are held in readiness to be erected at short notice. In Berlin the hospitals are already overfull, owing to the epidemic, which is also rife in Posen and West Prussia, where many of the schools have been closed. In Hamburg and Bremen the epidemic is reported to be assuming alarming proportions. In Scotland the focus of the epidemic still seems to be in Dundee, but there is a widespread prevalence over the whole of the country, with the exception of the extreme north and west. It is, indeed, very interesting to observe that on this occasion, as last year, the epidemic first became severe on the *eastern* coasts of Great Britain.

#### FREE EDUCATION ACT OF ENGLAND.

There has been a large increase in the number of scholars in the schools of England since the 1st of September, when the Free Education Act went into force. The managers of schools advised the parents of the scholars to put into savings banks, for the benefit of their children, the three pence per week that had previously been paid for the education of each child, and school savings banks were established to receive these deposits. This advice was followed by large numbers of parents in various parts of England, and the banks have already been of service. In the city of Manchester, for example, more than 5000 new accounts have been opened this month. The small funds thus deposited will be useful to the children hereafter.

#### A CASE OF PHYSIOLOGICAL ALBUMINURIA.

The final opinion about physiological albuminuria, says the *N. C. Medical Journal*, Nov. 1891, must be based upon the accumulation of well authenticated cases, and the following case is recorded as a part of that history.

A young man applied to a physician for insurance in an assessment insurance society, but when the urine was examined there was found to be albumen; he advised him to withdraw his application and consult his family physician about treatment. This he did in March, 1890. His urine was then examined by chemical and microscopical test weekly and then at longer intervals. There were no casts found, but albuminuria persisted. He was put on milk diet and gained flesh, but was never at any time in any state of health calling for treatment except for the albuminuria. He consulted other physicians in New York and Wilmington, and now, twenty months after the first discovery of albumen, he has gained flesh and increased in vigor, gaining in the time named, twenty-one pounds.

The clinical test of albuminuria in such a case is of more value than the revelations of the test-tube or microscope, and we think we may truthfully record this as a case of physiological albuminuria.

#### MANAGEMENT OF THE PAROXYSMAL INEBRIATE.

In the *Med. Rec.*, December 12, 1891, Dr. Tuckerman writes:

The assertion so confidently made by some to the effect that paroxysmal inebriety can be "radically cured," seems to me open to serious question. I have seen altogether too many "cured" cases relapse. There is little doubt, however, that under proper management the duration of the paroxysms can be materially shortened, and the intervals between them prolonged to such a degree that, in the majority of cases, the disease need no more interfere with a man's business than a gouty diathesis with occasional acute exacerbations. But to attain this result the condition must be treated as one of disease pure and simple, and the family and friends of the patient must heartily co-operate with the physicians in enforcing the necessary discipline. If the patient will himself co-operate, so much the better. The plan of treatment which has proven most effective in my own hands is as follows: The patient is put to bed and kept there for three or four days under the constant care of a nurse; if the patient be allowed to go about he does not recover physical tone as soon, and if he be left alone any length of time the fits of mental depression into which he is certain to fall greatly retard his recovery. Alcoholic liquor in every form is withheld from the first. Hot broth is given every hour, and hot milk at the usual meal times. Strychnia ( $\frac{1}{80}$  to  $\frac{1}{40}$  grain of the sulphate) is given every hour, and in case the heart acts feebly or the kidneys are sluggish it is combined with  $\frac{1}{160}$  grains of digitalin. At night a sedative is given subcutaneously. Terchloride of gold and sodium ( $\frac{1}{20}$  grain in thirty minims of water) has seemed to act kindly—more so than preparations of opium, either alone or combined with atropia or hyoscyamia, or those mixtures containing chloral or bromides; coffee, hot, and without milk or sugar, is allowed if the patient cares for it. Irregularities of the stomach and sluggish action of the chylipoietic system are corrected with small doses of calomel ( $\frac{1}{10}$  grain three to six times a day), combined with ipecac and soda. After the third day the patient is allowed to sit up, and easily digested solid food, such as rare beef-steak, etc., is added to his diet. From the fifth to the eighth day the nurse can be usually dismissed, and the patient returns to his business free from the craving for liquor for the time being. I add the qualification advisedly, for over-work, or over-worry, or prolonged privation of sleep, or any other cause which lowers the reserve of nerve force below a given point, will occasion a return of the craving, and with this craving comes the delusion of dipsomania, viz., that, since he is cured, he can take one glass and then stop. He takes it, but he doesn't stop. As a

precaution, after the patient has returned to his usual avocation, it is just as well to have him come to the office first daily, then every other day for a week or so, for his hypodermic of terchloride of gold. Every care should be taken to impress both the patient and his family with the necessity of avoiding those causes which in his case seem to determine the attack, and of coming to the physician when the prodromata (most prominent among which are indigestion and insomnia) first appear. By taking these precautions, patients often go two years, and even longer, without a relapse. To make a long story short, dipsomania is one of the graver manifestations of nervous exhaustion. The principles that underlie its successful treatment are the same that underlie the treatment of other extreme forms of neurasthenia, viz., rest, forced feeding, and tonics, with proper care after recovery to forestall a recurrence of the attack.

#### OVARIOTOMY; ITS USE AND ABUSE.

In presenting this subject before the Tri-State Medical Society (*Nashville Jour. Med. and Surg.*, Dec. 1891) Dr. Battey said that the fundamental idea in the operation which he had devised was to produce rest. The difficulty of curing many chronic diseases lies in the fact that rest is an impossibility, as with the heart, rest means death. Rest is an impossibility to an ovary.

The objects of the operations are:

1. The prolongation of life. Years ago Sir Spencer Wells said that he had added 5000 years to the sum of human life. Now it is probably double that.
2. The restoration of a disordered mind. There is a prejudice against operation, owing to the fact that cases have not been properly selected, and alienists want the ovariologist to cure their cases after they have exhausted every other means of cure; when it is often too late. Dr. Goodell asserted that an insane woman had no business with children, but Dr. Battey would hardly go so far.
3. The cure of epilepsy. As in the case of insanity, there is often some connection between epilepsy and ovaries. It does not follow that because a woman has epilepsy that her ovaries should be removed. Here Dr. Goodell had good results.
4. The relief of intolerable pain, especially when the pain has a tendency to produce that detestable habit, opium eating, a habit little better than insanity. Where the habit has been formed the operation will cure the case if the woman can break the habit.

One of the abuses of the operation is to perform a single operation for the notoriety it would bring. This ought to be a specialty as much as the eye. Success depends on the skill of the operator which can only come from experience. It depends also on native ability, and every man should study his natural talents in the light of statistics and choose the field where he is most successful.

The operation for the purpose of ovariectomy to stop child-bearing is a detestable practice. The operation should never be done without ample consultation; first, to protect the physician; second, in the protection of the interest of the profession at large; third, in the interest of the patient.

#### NOTES ON SCARLATINA.

The report of the Southwestern Hospital of London, published in the *Lancet*, is reviewed in the *Medical and Surgical Reporter*, October 17, 1891. Some points in regard to the desquamation in these 1008 cases and also concerning the treatment employed are worthy of special interest.

*Desquamation.*—The period and extent of desquamation varied in different cases within wide limits. In some instances, mainly in adults and very young

children, it was completed in less than six weeks. In others it was prolonged to twelve or even sixteen weeks. With the exception of a few in whom a condition of xeroderma was natural, no case was sent home until all sign of peeling had disappeared, discharges from mucous cavities and sores had ceased, and the urine had been for several weeks free from albumen. In infants, as is usual, peeling was but slight and transient. The average detention in hospital was slightly over nine weeks.

*Treatment.*—In the large majority of cases no special treatment was indicated, symptoms being dealt with as they arose. In those with severe throat and glandular affection, frequent syringing out of the fauces and nares with a solution of chlorine or boracic acid was most useful as serving to clear away offensive secretions and lessen discomfort. In such cases the frequent application of hot poultices was of great service. In restlessness and sustained pyrexia, cold and tepid sponging were useful to promote sleep, and sulphonal in some instances proved a valuable hypnotic. The cases were treated in bright and well ventilated wards, maintained at a temperature of 56° to 60° F., the average cubic space per bed being 2,000 ft. The diet during the pyrexial stage consisted of milk, beef tea, eggs, and ice, after which a more solid diet of milk pudding, bread and butter, with fish or meat, was given, and at the same time baths were ordered on alternate days. Stimulants were only employed in severe cases, usually in the form of brandy or champagne. Uncomplicated cases were allowed to get up at the end of the third week, and except in wet weather, sent out of doors for several hours usually each day, due care being taken that flannel was worn next the skin and the clothing otherwise warm and generally sufficient. Complications were dealt with as they arose, and, with the exception of otorrhœa, were rarely seen after the third week.

With reference to the treatment of scarlatinal nephritis, Dr. Cagney was not in the habit of using drugs in ordinary cases. A death from scarlatina nephritis in his hands is an event of the greatest rarity. In this series of over 1000 cases of scarlatina only one death occurred from scarlatinal nephritis, the child being admitted with nephritis, and dying a few days after in convulsions.

#### AFTER-TREATMENT OF REPAIR OF PERINEUM.

In a brief communication on this subject to the *Lancet* December 5, 1891, Dr. Nevins says:

Plastic operations on the female perineum are not by any means uniformly successful. Perhaps the most common cause of failure is suppuration, the difficulties in the way of keeping such a wound aseptic being very great. Foremost among these difficulties is the problem of keeping the patient's urine clear of the wound. The object of the present note is to briefly describe a plan which I have recently adopted for this purpose, with very satisfactory results. The usual treatment is to have the catheter passed three or four times in the twenty-four hours. This plan, however, is far from satisfactory, for several reasons. The female urethra is short, and the urine dribbles down by the side of the catheter; besides this, it is almost impossible to withdraw the catheter without letting a few drops of urine escape into the vestibulum vaginæ; but the worst difficulty of all is to avoid cystitis. No matter how thorough the precautions adopted to keep the catheter aseptic, they are rendered futile because it is almost certain to carry some of the non-sterilized vaginal secretions into the bladder. Exposing the urethral orifices and swabbing the surrounding mucous membrane with an antiseptic lotion before passing the catheter reduces the risk of cystitis considerably, but the following plan renders the fouling of the wound with

urine impossible, and avoids the risk of cystitis entirely. It consist of carefully administering an antiseptic vaginal douche twice or three times a day, and directing the patient to micturate while the douche is being given. If a hydrostatic irrigator (fountain syringe) is used, the force of the flow can be regulated to the greatest nicety, and there is not the slightest risk of dilating the vagina and so stretching the sutures. By using a flexible vaginal tube and directing the patient to pass it herself, pressing the point against the front wall of the vagina, the risk of pulling on the wound in inserting the tube is entirely avoided.

#### TREATMENT OF WHOOPING COUGH.

Löffler recommends the following solution to be used in the treatment of whooping cough:

℥.—Freshly prepared chloride of silver	1½ grains.
Water	2 pints.
Hyphosulphite of sodium, a saturated solution.	

Use by an atomiser, the liquid being directed into the pharynx. Repeat the application every two or three hours. This treatment is both prophylactic and curative.—*Med. News.*

#### WOUNDS OF THE FEMORAL VEIN.

In the *University Med. Magazine*, December, 1891, Dr. Martin sums up the results of his research upon this subject as follows:

1. The femoral vein is not the only channel by which the blood of the leg may reach the pelvis.

2. For the establishment of collateral circulation venous pressure, equal to that which is found in the arteries, is often requisite.

3. Wounds of the femoral vein inflicted by the surgeon in extirpation of tumors will not be followed by gangrene if the vein only is ligated. All wounds, however, become more serious in proportion to their proximity to Poupart's ligament.

4. Wounds of the femoral vein inflicted in tumor operations are liable to be followed by gangrene if vein and artery are both ligated.

5. Wounds of the femoral vein inflicted by weapons or sudden violence, and where the surrounding parts are previously healthy, are frequently followed by gangrene, even though the vein alone be ligated. This complication is rendered more probable by ligating both vein and artery.

6. The treatment of hæmorrhage from the femoral vein by ligature of the femoral artery should not be practised.

7. Lateral closure of vein-wound, where possible, is to be preferred to all other means of treatment. If the lateral ligature is employed it must be of fine silk, and the thigh must be flexed until it is vertical to the plane of the body.

Suture is to be preferred in this region; and in case both these methods are unsuccessful, forceps should be tried before the surgeon resorts to circular ligation. The forceps should be removed in forty-eight hours, the wound being carefully packed in the meantime.

Where the suture is employed, it should be of catgut and continuous, and should bring intima to intima. Over the first line of suture the sheath of the vessel should be sewed to give additional support.

8. The treatment of injuries to the femoral vein by closure of the external wound and the application of pressure is not to be recommended, since the blood-pressure in this vessel is higher than in other veins (Ollier records one success from this method).

To this statement an exception can be made. When the femoral vein is wounded with a ball of small calibre, the hæmorrhage is not necessarily marked or continuous. Antiseptic dressing and firm compression may in this case either allow the vein-wounds to heal entirely or may, if the artery is also wounded, favor the occurrence of an artero-venous aneurism—operation upon which will subsequently be far safer than ligature of the femoral artery and veins at the time of injury.

9. Where the vein is ligated the foot and leg should be held in vertical suspension, since this greatly aids in overcoming the resistance of the valves, which normally prevent collateral circulation.

10. The maintenance of asepticism and the support of the entire limb by careful bandaging are both requisite for the treatment of femoral vein injuries.

#### TYPHOID FEVER AND SALADS.

The Committee on Public Health, of the Clinical Society of Maryland, gave recently a distinct note of warning against the use of night-soil for the manuring and sprinkling of esculent vegetables, such as lettuce and cabbage. In this connection it is interesting to meet in the *British Med. Jour.*, Nov. 28, 1891, the following communication from Dr. Caton, of Liverpool, England:

At a time when the profession is interested in discovering every channel through which the poison of enteric fever may be communicated, I should like to call attention to a mode of contagion which has generally escaped notice. We all know the peril of drinking water which has been in the slightest degree contaminated by sewage, but do we realize the danger of eating salads, which, during their growth, have been irrigated by the market gardener with liquid manure? I chanced two years ago to observe a gardener bearing a long-spouted can in his hand, from which he poured two or three ounces of a brown, evil-smelling fluid upon or around a row of young lettuce plants. Inquiring the source of this fluid I was informed that it came from a neighboring cesspool. Being a constant eater of salads, this little incident caused me to meditate, and also to make further investigation from other gardeners as to the culture and bringing up of salad plants, and I discovered that it is usual for fluid composts to be thus used, whenever they can be obtained, to encourage the growth of lettuce, endive, celery, and similar vegetables. In the course of this frequent affusion with sewage it must happen that portions of the fluid fall upon the plant itself and percolate between its leaves. The watery portion will be absorbed or will evaporate, meanwhile the close circles of flattened stems and leaves of a celery or lettuce plant form a trap or filter which will hold and retain all solid particles, such as the bacilli or other solid contagion of enteric fever, if any be present.

The gardener, of course, never thinks of inquiring into the source of his liquid manure; it is no part of his business to consider whether enteric fever has existed in any adjacent cottage which drains into his cesspool or manure pond. Thus it may happen that the householder, who has strictly guarded his water supply and his drainage from all possibility of enteric contagion, has lettuce or celery plants brought into his house which carry disease and death hidden within their delicate white leafage. Whether he and his family are poisoned or not may now depend upon the washing the vegetable receives. It is not easy to cleanse celery and lettuce in such a manner as to remove all solid particles, if such exist, from the closely-gathered leaves about the heart of the plant; moreover, not one cook in fifty knows the importance of thorough washing. Since discovering the above facts I rarely eat any salad which is not grown in my own

garden, and dressed by a cook who knows the perils of imperfect washing, but I always contemplate other salads with interest and I have repeatedly discovered in them minute scraps of decaying organic matter, apparently derived from the market gardener's liquid manure can.

One meets occasionally with cases of enteric fever, the origin of which is difficult to ascertain. I must confess I have never yet been able to prove contagion from this source, but the difficulty of such proof is overwhelming—to trace back the lettuce a patient consumed a fortnight ago to its birthplace in some French or English country garden, and to ascertain whether typhoid existed in the vicinity, passes the wit of man. I have, however, had grave reason to suspect such an origin in certain cases where every other cause seemed excluded—it is evidently possible. I should like to know if any of your readers agree with me in the opinion I have expressed, and, if so, I feel strongly that the public ought to be warned of the danger.

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### Medical Items.

Three life insurance companies in Great Britain have given up medical examinations of applicants for insurance. They hope to avoid loss by giving only a portion of the premium in case of the insured's death before the lapse of a certain number of years.

The time a medical student has to spend in college is: Austria, five years before obtaining his degree; Belgium requires eight, Canada four, Denmark seven, England four, France four, Holland eight, Hungary five, Italy eight, Norway eight, Portugal five, Russia five, Spain two, Sweden ten, Switzerland eight, and the United States three or four.—*Medical Examiner.*

The commotion in the College of Physicians of Philadelphia, of last spring, in which the college refused to accept the recommendation of its censors, and the censors tendered their resignations because of this evident lack of confidence, has finally been settled. Dr. Joseph Price has been requested to resign from the College because he had been expressing his opinions respecting Fellows of the College too publicly. The members of the Council have withdrawn their resignations. Possibly the event may teach the wisdom of using the tongue less freely when the reputations of fellow physicians are at stake.—*Amer. Lancet.*

Imitating the example of the State of New York, where a similar law was passed in 1890, the State of Maine has passed the following law, which was approved by the Governor on March 28: "Section 1. Should one or both eyes of an infant become reddened or inflamed at any time within four weeks after its birth, it shall be the duty of the midwife, nurse or person having charge of said infant, to report the condition of the eyes at once to some legally qualified practitioner of medicine of the city, town or district in which the parents of the child reside. Sec. 2. Any failure to comply with the provisions of this act shall be punishable by a fine not to exceed \$100, or imprisonment not to exceed six months, or both. Sec. 3. This act shall take effect on the first day of June, eighteen hundred and ninety-one."

A recent calf-feeding experiment made at the Iowa Agricultural Experiment Station seems to indicate that: 1, a ration of skim-milk and ground flaxseed compares favorably with a new-milk ration for young calves; 2, the larger gain came from the whole milk, but a part of it was due to the individuality of the

calves, and good results and thrifty growth were made on skim-milk and ground flaxseed; 3, the skim-milk calves were interrupted less in their growth by weaning than the whole milk calves; 4, a saving in value of butter fat alone of \$1.11 per month on each calf was effected by substituting the ground flaxseed; and 5, the cost of producing a pound of gain was 7.6 cents for the fresh-milk ration and 5 cents for the skim-milk ration.

Dr. L. Webster Fox says that savage races possess the perception of color to a greater degree than do civilized races. In a lecture lately delivered before the Franklin Institute, Philadelphia, he stated that he had just concluded an examination of 250 Indian children, of whom 100 were boys. Had he selected 100 white boys from various parts of the United States, he would have found at least five of them color-blind; among the Indian boys he did not discover a single case of color-blindness. Some years ago he examined 250 Indian boys, and found two color-blind, a very low percentage when compared with the whites. Among the Indian girls he did not find any. Considering that only two females in every 1,000 among whites are color-blind, he does not think it surprising that he did not find any examples among the Indian girls.

The next meeting of the American Academy of Medicine will be held in Detroit, Michigan, in June, 1892. According to the statements of its secretary, Dr. McIntire, the Academy believes that no one should practice medicine without preparation; that this preparation should be thorough on every side; that no one can, to the best advantage, enter upon the technical medical studies until his mind has been trained to study and has been furnished with certain preparatory information; that for anyone to be able to receive the greatest benefit from his technical studies he must receive the best preparation to enter upon these studies. The Academy acts upon this belief by limiting its membership to college bred men, requiring of them evidence of a full preparatory training equivalent to a course leading to the A. B. degree, and a full course in medicine; by devoting its meetings and its associated efforts to discussions and investigations on educational topics as related to the physician, and in a less degree, to the broader topic of the sociology of the medical profession.

The Second Annual Session of the Association of Military Surgeons of the National Guard of the United States will be held at St. Louis, Mo., April 19th to 21st, 1892. An interesting programme of addresses by prominent surgeons of the National Guard and the United States Army has been arranged, a number of scientific papers on Military and Accidental Surgery will be read and discussed, and all matters pertaining to the health, usefulness and welfare of the civilian soldiers will receive attention. The afternoon of one day will be set apart for an object lesson from the "Manual of Drill" by hospital corps of the United States Army, detailed for this purpose. This will be a very important as well as an instructive feature of the session. The evenings will be given up to entertainments, receptions and banquets, which the medical profession and citizens of St. Louis have planned for their guests. The committee of arrangements, of which Dr. Eustathius Chancellor, 515 Olive Street, St. Louis, is chairman, have received the assurance that transportation will be reduced on all railroads and steamboats to and from this meeting. The several hotels have promised a low and uniform rate, which will be announced at an early date. It is anticipated that not less than 500 surgeons and assistant surgeons of the National Guard of the United States will be in attendance, to all of whom the committee of arrangements extend a most cordial welcome.



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## CONTENTS

### ORIGINAL ARTICLES.

The Part Played by Leucocytes in Inflammation in the Light of Recent Bacteriological Investigations. By Wm. Travis Howard, Jr., M. D., of Baltimore. . . . . 199

Report of a Case of Cystic Degeneration of the Chorion (Hydatiform Mole). By F. C. Bressler, M. D., Baltimore. . . . . 206

### EDITORIAL.

The Leucocyte. . . . . 208

Influenza, with Nausea and Vomiting. . . . . 209

Beef Tea. . . . . 210

### MEDICAL PROGRESS.

Notes from a Leper Hospital in Norway.—Eruption of the Deciduous Teeth, and the General Symptoms.—Albuminuria.—Ainbum.—Electric Current for Uterine Hæmorrhage.—Relation of Albuminuria to Surgical Operations.—Systemic Infection in Gonorrhœa.—Sulphuring or Bleaching of Dried Fruit.—Mediastino-Pericarditis. . . . . 211

MEDICAL ITEMS. . . . . 219

## Original Articles.

### THE PART PLAYED BY LEUCOCYTES IN INFLAMMATION IN THE LIGHT OF RECENT BACTERIOLOGICAL INVESTIGATIONS.†

BY WILLIAM TRAVIS HOWARD, JR., M. D., OF BALTIMORE.

It is well in the beginning to describe what is meant by the term leucocyte. In the normal blood one finds the following varieties of colorless elements.<sup>1</sup>

(a) Lymphocytes. Small cells about the size of red corpuscles, with a large, round, deeply-staining nucleus, surrounded by a narrow rim of non-granular protoplasm.

(b) Large mono-nuclear leucocytes. These are large cells, several times as large as red corpuscles, with a large oval or elliptical nucleus, and a considerable rim of non-granular protoplasm.

(c) Transition forms. Cells with irregular nuclei.

(d) Polynuclear leucocytes. These are about the same size or somewhat smaller than the mono-nuclear variety. The nucleus consists of a long intensely-staining body, which is bent and twisted on itself into bizarre and irregular shapes. Often there seem to be two or three nuclei in the cell. The protoplasm of the cells shows a very fine neutrophilic granulation.

(e) Eosinophiles. Cells of about the same size as the polynuclear form, with a single round, ovoid, or polymorphous nucleus, and containing large, round or ovoid eosinophilic granulations.

†Read at the 732d regular meeting of the Medical and Surgical Society of Baltimore, Dec. 10, 1891.

These varieties in the normal blood bear a nearly constant proportion to one another, as follows: lymphocytes, 20 to 30 per cent.; polynuclear, 60 to 75 per cent.; mono-nuclear and transition forms, 6 per cent.; eosinophiles, 2 to 4 per cent.

It has long been known that the only cells that make their way through the vascular walls are the polynuclear leucocytes. These are the principal cells, both as regards numbers and variety, found in the exudations in acute inflammations.

To clearly point out the relations that these cells hold to the inflammatory process and to the other cells, it is necessary to review briefly the part they play.

The first influence of any trauma producing an injury or death of tissue is shown by the various vascular disturbances peculiar to inflammation, and it is not probable that we can have any of the various processes which make up the sum of the vascular disturbances and the wandering out of leucocytes, which we know as inflammation, without a direct lesion, which in most cases takes the shape of a complete necrosis, of the cells of the tissue. The vascular disturbances are shown in a dilatation of the vessels of the part and a retardation of the blood current, and have for their final results the passage of the polynuclear leucocytes through the vascular walls and their accumulation in the surrounding tissue, forming in some cases a definite wall around the point of necrosis, or in other cases forming a diffuse infiltration through the tissue, being accumulated principally in the intercellular spaces. Following this leucocytic invasion there is a proliferation of the fixed cells of the surrounding tissue, leading to the reparation of the injury and the final substitution of cicatricial tissue for the tissue primarily injured and destroyed.

So we may define inflammation as the reaction of living tissues to a trauma. That this is what happens in all inflammations has long been known. But the interesting question of *why* the leucocytes have this property of wandering from the vessels into the tissues, and the exact nature of the conditions and influences under which it takes place, have until recently been a *terra incognita* in pathology. To account for this, many theories have arisen and fallen, and much interesting and valuable work has been done. To review the more recent work that has shed light on these questions is the object of the present paper.

Schlawewsky first and, after him, Weigert, accounted for the accumulation of the leucocytes along the vascular walls, preceding their passage through into the surrounding tissue, in two ways: first, by the physical properties of the corpuscles themselves; and second, by the altered relation of the circulation. That is, the circulation being very much slowed, the corpuscles by their physical properties stick to the sides of the vessel, and thus accumulated they gain their exit by their own active vital movements; or, according to Cohnheim's theory, by a physical process of filtration. But why they make their way from a distance to the point of trauma was left unexplained.

Thus in an inflammation artificially excited in the centre of the cornea the leucocytes make their way from the vessels of the sclera and conjunctiva along the corneal lymph spaces, and finally form a distinct wall around the necrotic point. They show no tendency to pass in the other direction into the sclera and conjunctiva, but pass into the cornea as if irresistibly driven by a *vis a tergo* or drawn thither by a magnet. This process invariably happens at the point of a trauma.

Engelman<sup>2</sup> was the first to appear in this new and rich field of research, which has thrown so much light upon the whole subject of the relations of the leucocytes

and bacteria to inflammation. From his experiments, which showed that many bacteria have an especial attraction for oxygen, and are found in great numbers in the neighborhood of air vesicles accidentally present in the culture fluids, it is learned that these organisms are not to be regarded in the same light as other small but non-vital particles, but that they can be attracted in certain directions.

Before Engelman, Weigert made the observation that, in blood drawn from patients with relapsing fever and allowed to stand in an open vessel, the spirochaetæ of Obermeyer were more numerous on the surface, and advanced, against the law of gravity, from the deeper portions to the surface.

Of more importance than this work is that of various botanists on the higher forms of cells.

Stahl<sup>3</sup> observed that the plasmodium of *ethylium septicum*, one of the myxomycetæ found in rotten tan bark, can be excited into motion by certain chemical substances contained in the tan bark. If this plasmodium is placed in water on a glass plate, it lies motionless; but if a drop of tan infusion is placed in its neighborhood, the organism moves actively towards this. If, under the same conditions, a drop of a solution of glucose is substituted for the tan infusion, the opposite effect is observed—the plasmodium moving with corresponding rapidity from it. Of especial interest is his observation that the organism can acquire an attraction for certain chemical substances. For instance, if the experiment with the glucose is repeated a number of times, the organism, instead of being repelled, is attracted by it as by the tan infusion.

Du Barry<sup>4</sup>, in his studies on the myxomycetes, has confirmed the work of Stahl. But he further observed that the absorption of solid particles by the plasmodia is determined solely by the chemical properties of the solid matters used. While some organisms will greedily absorb particles of carmine, others will not.

Pfeffer<sup>5</sup> widened our knowledge on these properties of organisms considerably by his researches in 1886. He showed that the spermatozoa of the prothalamium of certain ferns were attracted by very dilute solutions of certain chemical substances and that micro-organisms generally were attracted by some substances and repelled by others. His most valuable contribution was, however, to give us a simple and effective method for carrying on such experiments. This method consists in placing very small capillary glass tubes, with one end sealed and partially filled with the chemical substance to be experimented on, in fluids containing the organisms. If the substance has an attraction for the organisms the latter enter the tubes. To this power of attraction he gave the name of chemotaxis. When organisms are attracted to a substance he calls it positive chemotaxis and when they are repelled by a substance negative chemotaxis. In his experiments he found some substances which were indifferent, neither attracting nor repelling organisms.

The first observations made on leucocytes were those of Hess.<sup>6</sup> He sought to learn the fate of pathogenic bacteria injected in pure culture into the circulation of immune animals; that is, animals capable of resisting the organisms so inoculated. For this purpose he injected anthrax bacilli into the circulation of the frog. It had long been known from the results of the observations of Metschnikoff and others that the bacilli are taken up by the leucocytes of the frog, and there undergo gradual destruction. Hess found that, even though immense quantities of anthrax bacilli were injected into the frog's circulation, at the end of three hours very few could be found free in the blood, and at the end of six hours none at all were to be discovered. When Ziegler's plates, between which a small portion of a culture of virulent anthrax bacilli was placed, were introduced

into the tissues of the rabbit, one of the most susceptible animals to anthrax, comparatively few leucocytes entered the space between the plates. If, however, instead of virulent anthrax bacilli, an attenuated form, toward which the animal is immune, was used, the leucocytes entered the space in large numbers, and formed a wall around the organisms.

Lurbarsch<sup>7</sup> found on placing a portion of the lung or spleen of a mouse, dead of anthrax poisoning, into the dorsal lymph space of the frog, that in three days it was enclosed by a wall of leucocytes. He also observed in the immune animal a striking difference between the attraction of the leucocytes for the dead and for the living bacilli.

Lebert,<sup>8</sup> as the result of his studies on the keratitis, produced by the inoculation of the cornea of rabbits with pure cultures of *aspergillus niger*, came to the conclusion that there is developed at the seat of inoculation a chemical poison, which, becoming diffused into the surrounding vascular tissues, excites inflammatory action. He further found that the injection of dead pus organisms into the cornea would produce an intense purulent inflammation. He succeeded in isolating from the organisms used a chemical substance which would produce inflammation. The substance, to which he gave the name of phlogosin, he supposes exerts an attraction for the leucocytes in the same manner that the substances attracted the plasmodia in Pfeffer's experiments. He found, on placing glass tubes similar to Pfeffer's, partially filled with various substances that excite inflammation, into the anterior chamber of the eye of the rabbit, that they became filled with leucocytes. Other, but indifferent substances, exerted no such attraction. We see from these experiments that the polynuclear leucocytes, which are the only variety capable of amœboid motion, have the same capacity of being attracted or repelled by certain substances as other amœboid organisms.

Peckelharing<sup>9</sup> found, on placing small pieces of sponge, some saturated with indifferent fluids and some with anthrax cultures, under the skin of frogs, that the leucocytes enter the latter in much greater numbers than the former.

An extensive series of researches on this property of the leucocytes were carried on after the method of Pfeffer, by Massart and Bordet.<sup>10</sup> They placed tubes filled with various substances in the abdominal cavity and in the tissues of frogs. By a number of substances, prominent among which were cultures of bacteria, leucocytes were attracted. In the tubes containing indifferent substances a few leucocytes were found and their presence was attributed to the tactile excitability of the leucocytes. This, though not so strong as their chemical excitability, was longer preserved.

Gabritchevski<sup>11</sup> in his experiments on the chemotactic power of leucocytes made in Pasteur's laboratory, studied the attraction of leucocytes for bacteria and various other substances. He experimented on frogs, certain lizards, and the subcutaneous tissues of the rabbit, using Pfeffer's tubes. Tubes, containing pure cultures of the various kinds of bacteria experimented with, were allowed to remain in the tissues twenty-four hours. The tubes, on removal, were counted for the number of leucocytes contained. Among other substances the action of jequirity, papayatin, lactic acid, and bicarbonate of sodium was determined. Under similar conditions there were always found more leucocytes in the tubes from the tissues of the rabbit than in those from the frog, sometimes six times as many. He found among the principal substances producing a negative chemotaxis or repellant action on the leucocytes, concentrated solutions of the salts of sodium and potassium, lactic acid in any concentration, quinine, alcohol, jequirity, glycerine and bile; among the indifferent substances, distilled water, phenic acid, phloriozone, glycogen, bouillon and carmine powder suspended in water.

It is an interesting observation that in his experiments fresh cultures of the bacilli of chicken cholera exerted a marked negative chemotactic action on the leucocytes of the rabbit, but with old cultures the result was variable. Of the substances exerting a marked positive chemotactic action, were cultures of various bacteria, especially the pus organisms and the bacillus of typhoid fever. The most striking results were obtained in the rabbit by the typhoid fever bacillus, and in the frog by the bacillus pyocyaneus.

Buchner,<sup>12</sup> in a series of articles, has brought out the remarkable fact that it is not the bacteria themselves and the products of their vital activity which have the chemotactic power of attracting leucocytes, but that it is the substance of the bacteria themselves and the chemical constituents of their bodies which attract them. He has succeeded in extracting from the bodies of the bacteria, by subjecting them to the action of a dilute solution of caustic potash, a substance which has a very powerful positive chemotaxis for leucocytes. Such products can also, according to him, be obtained from the necrotic tissues themselves. He finds that the alkali albumins of the products of tissue disintegration exert a similar powerful attraction.

He shows further that certain bacteria produce a local inflammatory action under some circumstances, and a general disturbance with little or no local reaction under others. Thus, the cultures of attenuated anthrax bacilli produce an intense local reaction when inoculated into rabbits, but no general effects are produced; but the cultures of the virulent organisms produce general effects, the animal dying with enormous multiplication of the bacilli in the blood, but with little or no reaction at the point of inoculation.

In man, virulent anthrax bacilli produce primarily a carbuncle, which may or may not be followed by general infection; in the rabbit they are found in large numbers in the blood and the animal dies from septicæmia. In the same manner, the pneumococcus produces a general septicæmia in animals; while in man we find the most active inflammation anywhere known—acute croupous pneumonia. According to Buchner, in all these instances the inflammation, or rather the accumulation of the leucocytes, is produced by the destruction of the bacteria and the liberation of the alkali albumins of their bodies, as well as the alkali albumins produced by the necrosis of the animal tissues.

There is at first glance an apparent difficulty in reconciling these statements with the early lesions found in typhoid fever. This apparent difficulty in the case of the typhoid bacilli, which in the experiments with Pfeffer's tubes are shown to possess a strong positive chemotaxis for leucocytes, while in the early stages of typhoid fever no leucocytes are seen, is cleared up when we consider that in the tissues in the early stages the conditions are so favorable for the bacilli that none of them die, while in the tubes probably many of them perish and then their products attract the leucocytes.

In my own experiments on the so-called organization of the blood-clot, several interesting points in this connection are illustrated. In an ordinary blood-clot in the tissues, to which micro-organisms do not gain access, one of the first changes is the passage into the clot of polynuclear leucocytes. In a large clot, even in a few hours, numbers wander in and scatter in all directions. They are probably attracted into this by the chemical substances resulting from the death of certain elements in the blood. The fibrin present in the clot seems to have an especial attraction for them. When the clot is infected, accidentally or intentionally, a great many more leucocytes wander in. In this case, too, they are scattered diffusely; but, in addition to this, one sees here and there dense areas

of them. These areas are analogous to miliary abscesses. It is an interesting observation that these areas may be found at a distance from the blood supply—far in the clot. This may occur without any suppuration.

The resistance of the blood-clot to infection is an interesting fact of practical importance, as shown by some experiments on the organizing blood-clot in dogs, done by Dr. Welch<sup>13</sup> and myself. We found that the staphylococcus pyogenes aureus does not multiply in the blood-clot; and that, while the number of the leucocytes is greatly increased, the clot infected with these organisms undergoes the same changes as the non-infected clot, and organizes in about the same time. Numbers of leucocytes in scrapings of such an infected clot are seen to contain the micrococci, but the organisms are killed or their virulence is destroyed, probably by the blood-serum in and around the clot, as Nuttall<sup>14</sup> has shown in his blood-serum experiments. The fact that there are more leucocytes seen in the infected than in the sterile blood-clot is probably due to the double attraction of the positive chemotactic power of the normal blood-clot and the bacteria.

What Dr. Welch and I found in the experimentally infected blood-clot accords with the brilliant results of Halsted<sup>15</sup> in the management of the dead spaces of infected wounds with the blood-clot.

That the soluble toxic products of many pathogenic bacteria, especially those of the infectious diseases, exert a positive chemotaxis for leucocytes is an interesting point brought out lately by several observers. Among the more important are the observations of Welch and Flexner<sup>16</sup> in their work on experimental diphtheria. They noticed that in the lesions in the various organs, far removed from the seat of infection, following the necrosis of the tissue-cells, there is an intense infiltration of the necrotic area with leucocytes. In a case of tuberculosis of the knee-joint in which tuberculin was used, the patient afterwards dying of palmonary tuberculosis, Flexner<sup>17</sup> observed a more extensive necrosis of the tubercles, and much greater numbers of leucocytes than under ordinary circumstances.

Prudden<sup>18</sup> has recently shown in a series of articles that dead tubercle bacilli have a strong positive chemotaxis for leucocytes. In one series of experiments he injected emulsions of sterilized tubercle bacilli into the ear vein of rabbits. At the point of inoculation in a few days there was a raised area containing sterile pus. Wherever the bacilli lodged in the rabbit, there was a dilatation of the surrounding vessels, and an escape of leucocytes into the surrounding tissues.

In a more interesting series of experiments Prudden injected sterilized tubercle bacilli into the trachea of rabbits. In twenty-four hours the cut surface of the lungs showed large numbers of scattered, white, dense, airless areas, corresponding to the bronchi and their adjacent air vesicles. In some places the air vesicles about these areas were congested. The bronchi contained large numbers of tubercle bacilli and leucocytes. Where the number of the bacilli was greatest, the leucocytes were present in proportionately large quantities. In the air vesicles wherever bacilli were present they were accompanied by leucocytes. The mucous membrane of the bronchi was intact. He was not able to isolate a bacterio-protein from the dead tubercle bacilli.

From all these experiments and observations we see that active inflammation at the point of injury, when produced by infection from pathogenic bacteria, is rather a favorable sign than otherwise. For it points out clearly that the tissues, although extensive necrosis may be produced, have the power of destroying and withstanding the effects of numbers of bacteria, and that the leucocytes in the

part and the degree of the inflammatory disturbance are an index of the destruction of the organisms. As we have defined inflammation as the reaction of living tissues to an injury, so we would regard the intensity of this reaction as indicative of the ratio existing between the amount of poison which is to be combated by the tissues and the amount of resistance of which the tissues are capable.

It is well known, for instance, that those wounds infected at autopsies, at the dissecting table, etc., are the most dangerous in their final results where there is least inflammatory disturbance at the seat of the primary injury. Where there is much local inflammatory disturbance usually the products of the bacteria are resisted and there is no general infection. In the one case there is only the local abscess, with possibly secondary infection of the neighboring lymph glands; and in the other a general septicæmia.

The normal number of leucocytes<sup>19</sup> to the cubic millimetre in the adult is about ten thousand. In some acute diseases, their numbers may rise to thirty-six thousand, but more often it is from fifteen to twenty thousand. In some adynamic conditions the number may sink as low as two thousand.

In this connection Tchistovitch<sup>20</sup> has recently published some interesting researches. He found that after the inoculation of rabbits with attenuated cultures of the pneumococcus, in every case there was an increase in the number of leucocytes in the blood, lasting from one to two days and disappearing on the recovery of the animal. After inoculation of virulent cultures, there was a marked diminution in the number of leucocytes, becoming more evident towards death. In some cases the animal became very ill, and the number of leucocytes greatly decreased; this was followed by a gradual increase in the number of leucocytes, and the animal recovered.

Buchner's theory that it is the chemical substances of the bacterial bodies and the alkali albumins produced by the death of the bacteria that cause the reaction of the tissues, explains many doubtful points in our conception of the mode of infection.

There are many points of practical importance to be derived from this work. Thus, in the treatment of inflammations, we see the worse than useless procedure of trying to abort them by the use of the ice-bag and cold applications, methods that have been and still are largely used in Germany. The very thing that the ice-bag is supposed to do, that is, to lessen the hyperæmia of the part, is the very thing that is most to be avoided. It is desirable to have the most active circulation and hyperæmia of the part affected, both to obtain the effects of the germicidal power of the blood serum in its greatest efficiency in the central point of the inflammation, and to place the surrounding tissues, by the activity of the circulation, in such a condition of nutrition that will best enable them to resist the destructive influences constantly emanating from the central point of infection. It would seem far more rational that—instead of cold—warm applications, such as hot poultices and the hot water bag, should be used. It is not improbable that the greater part of the happy results obtained by the use of the so-called iodoform poultice in acute inflammations is due to the warmth induced. How else can the good results and relief of pain obtained by the use of the actual cautery and massage in acute and chronic inflammations be explained?

As irrational as the use of cold applications, is the use of drugs like ergot and aconite in acute croupous pneumonia. In this disease, too, a similar plan of endeavoring to aid and further the inflammation and not to combat it, should be our guide. In any case it is not the inflammation that is to be feared and

fought—the inflammation being the natural reaction of the tissues to an injury and our friend and ally. But it is the disease, the poison which necessitates the inflammatory reaction, that is to be fought. Unless this is borne in mind and acted upon, those cases that terminate happily will do so in spite of, and not on account of, the treatment received.

Klemperer and Klemperer<sup>21</sup> have recently shown that, in the course of an acute infection with the pneumococcus of acute croupous pneumonia, substances are formed in the blood-serum inimical to the action of the organism, and when a sufficient amount of these substances is formed, crisis takes place. Serum containing these substances, inoculated into another animal suffering with the disease, produces a definite cure. This line of work promises much towards the treatment of infectious diseases in the future.

The whole part that the leucocytes play in the inflamed area we do not yet know. It is certain that they take up living and dead bacteria and the results of tissue necrosis into their bodies and carry them away. Many die in and around the central point of every infection, and it is probable that by their death substances inimical to bacterial products are set free. It is not improbable, also, that by their death substances injurious to bacteria are produced.

In conclusion, I desire to express my indebtedness to Dr. Councilman for many valuable suggestions.

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## REPORT OF A CASE OF CYSTIC DEGENERATION OF THE CHORION (HYDATIFORM MOLE.)†

BY FRANK C. BRESSLER, M. D., BALTIMORE.

Mrs. K., aged 35, mother of seven children, missed her menstrual flow five months ago; at the end of the second month began to notice some discharge of blood; at first quantity was small, but gradually became greater. At first the loss of blood was intermittent, but quickly it became constant. In this condition she attended to her household duties as well as taking care of a small grocery store. She consulted her regular family physician, who was unable to stop the flow. She likewise was seen by another prominent physician, whose treatment met the same fate as her regular attendant. In this condition she attended to her various duties for three months, when she came under my care. I obtained the above history; also that she had never had any trouble at her confinements, nor had a miscarriage. I found her decidedly anæmic, complaining constantly of symptoms pointing to loss of blood. She states that she has lost nothing else but pure blood, which is always flowing; sometimes so freely as to

†Read at the 732nd meeting of the Medical and Surgical Society of Baltimore, Dec. 10th, 1891.



drop on the floor. I further found that she had had nausea and vomiting even up to date of delivery. I demanded what was necessary for her future welfare, an examination, which was reluctantly granted, this examination to be made without instruments—in short, digital, under cover. I found her much soiled from blood. On introducing finger into vagina found os patulous—open so that my index finger could enter uterine cavity. Was struck by the absence of fœtus and felt as if I had a soft fleshy mass to contend with. I decided, after carefully listening for fœtal heart-sounds and finding them absent, that my patient had some abnormal pregnancy; what it precisely was, I felt unable to say. Knowing that she would soon have to succumb owing to loss of blood, I decided to try her on cautious doses of ergotole and *fld. ex. viburni prunifolii*, in 20 drop doses every two hours. My object was to set up uterine contractions, thus emptying the uterus, if possible, without instrumental interference, and thus find out what I really had to contend with. Immediately after taking several doses, she noticed slight pains; these pains fluctuated for several days, when suddenly on the morning of the 5th day of the taking of the above drugs, she had several severe uterine pains, which were attended by the expulsion of a large amount of these hydatids. Finding that some seemed to be retained, I made an effort to remove them, but this was too painful, so I administered chloroform, went into the uterus and thoroughly cleared it out, then followed it up by the administration of the above prescription.

On the second day the odor of the lochia was somewhat fetid, but under hot carbolized vaginal injections this disappeared. She suffered with no bad symptoms afterwards and made a safe recovery, except the anæmic condition. I should say, the loss of blood was considerable while I was trying to cleanse the uterus of the hydatids.

As regards the causation of this condition, authors are not agreed, and I think it safe enough to say that we are ignorant of the influences that are productive of it. I have thought it possible that the taking of various drugs to induce labor or miscarriage at an early period of pregnancy, possibly before the second month had elapsed, might act as a decided factor by inducing a morbid influence on the vascular supply to the villi and possibly decidua, tending thereby to induce this cystic condition. This point may be worthy of further investigation. I simply suggest this as a hint, since I discovered that my patient took pennyroyal pills when she discovered that she was pregnant, at the first month, but they failed to produce labor; hence my suggestion.

As to treatment—only one thing can be done, namely: clear out the uterus carefully and thoroughly and prevent septic infection.

1713 Bank St.

#### AN ATTEMPT TO RENDER TOBACCO HARMLESS.

Smokers may be pleased to learn that Dr. Gautrelet, of Vinchy, claims to have discovered a method of rendering tobacco harmless to mouth, heart, and nerves, without detriment to its aroma. According to him, a piece of cotton wool steeped in a solution (five to ten per cent.) of pyrogallic acid, inserted in the pipe or cigar-holder, will neutralize any possible effects of the nicotine. In this way not only may the generally admitted evils of smoking be prevented, but cirrhosis of the liver, which in Dr. Gautrelet's experience is sometimes caused by tobacco, and such lighter penalties of over-indulgence as headache and furring of the tongue, may be avoided. Citric acid, which was recommended by Vigier for the same purpose, has the serious disadvantage of spoiling the taste of the tobacco.—*Science*.

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BALTIMORE, JANUARY 2, 1891.

**Editorial.****THE LEUCOCYTE.**

In another column we present to the reader an article from the pen of Dr. Howard, in which he treats of the part which the white blood corpuscle plays in the fight of the system against germ-disease. We invite the attention of our readers to the article; for, although many of its terms are unfamiliar to the ordinary practitioner, it deals with investigations which are among the chief agencies in the present advance of medical science, and with discovered facts which will doubtless be worked into the foundations of the healing art of the future. The study of the life and activities of the minute cells of which the body is built, and especially of such an energetic individual as the leucocyte, is of interest from various points of view.

To the scientist it is a field of never-ending discovery, testing by its minuteness his skill in manipulation and by its elusiveness his inventive powers. The observation of the structure and vital relations of the teeming millions which people the blood-stream grows ever more fascinating as one new variety of corpuscle after another is distinguished and studied.

To the philosopher it affords fruitful themes for reflection as he observes the adaptation of means to ends; the provision made against possible disease-invasion; and the apparent intelligence with which this little being moves and acts. If he be a man who acknowledges in the structure of the human body the skillful hand and the guiding mind of the Creator, he follows with reverent attention the unveiling of those mysterious processes of life which lead us ever closer to the yet-untouched mystery of the life-principle.

To the physician the practical inferences which Dr. Howard draws from his studies of the life of the leucocyte are of interest, suggesting the philosophical

foundations for methods of treatment long ago learned at the bedside. We cannot blindly follow the writer in his therapeutic suggestions. Clinical observation is the final test to which all scientific teachings in regard to therapeutics must be submitted. The comfort of the patient will often be a better guide to the favorable condition for leucocytic activity in an inflamed part to which cold or hot applications have been made, than any preconceived theoretical teachings.

#### INFLUENZA, WITH NAUSEA AND VOMITING.

This protean disease has recently exhibited itself in a new form in the community. We hear of many cases in which the patient suffers the most intense and persistent nausea, with continual striving to empty the stomach. At first sight one is reminded of the nausea of certain forms of nephritis; yet the urine is freely secreted and in the fatal cases the mind is clear to the end. The nausea resembles somewhat that of sea-sickness; yet the stomach in many instances retains the food put into it, the repeated retchings failing to bring up more than a small quantity of mucus.

To an attentive observer it is evident that the nausea is not due to local trouble in the stomach, but is the result of grave disturbance in the central nervous system.

In aged patients of 50 years and upwards, this persistent sick stomach is an extremely unfavorable symptom. If it persists in spite of remedies, it wears the patient out and breaks his rest; and soon symptoms appear indicating dangerous or fatal depression of the nervous system—sleeplessness, jactitation, periodic exacerbations of the cough and nausea, and intermittence or irregularity in the respiration.

The treatment in this form of the influenza is directed toward the relief of nausea, the procuring of sleep and the support of the bodily powers. For the nausea, it is said that rectal injections of chloral hydrate, grs. xv to xx, have been beneficial in Europe. Calomel in a few doses of  $\frac{1}{10}$  to 3 grains may bring the intestinal secretions into order and allay the nausea for a time. Iced champagne and brandy, milk and lime water, etc., are useful in quieting the stomach and affording nourishment. The best remedy for nausea which the editor has discovered in the cases which he has treated is the sulphate of codeine,  $\frac{1}{2}$  grain given in a small capsule with aromatic sulphuric acid, q. s., every two, three or four hours. In each instance this drug has given at least temporary relief, and in one case it seemed to be the agent in averting a fatal termination. As this form of influenza is less severe during the daytime and returns with increased severity at night, the physician should keep his aged patient in the recumbent position in bed for several days after convalescence begins, forbidding all general conversation, heavy food and exciting influences; else, after a day of apparently complete recovery, he may have a night of relapse into a worse state than before.

It is evident that the peculiarly depressing qualities of the atmosphere which were observed during Christmas week were extremely unfavorable for such patients. This damp, warm weather, with cold fogs at night, seems to have in some way been associated with and productive of the graver incursions of epidemic influenza during the past three years.

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#### BEEF TEA.

The opinion is frequently expressed nowadays by physicians that beef tea is of no value as a food, but is simply a solution of stimulating or refreshing saline elements. If this is so it should be generally known, for beef tea is often administered in adynamic states, as a substitute for, or in alternation with, nourishing substances such as milk.

We are convinced that the prejudice against rightly-prepared beef tea is without proper foundation; and we prefer this home-made substance to the different meat extracts sold in the shops, which may vary greatly in their composition, and are often disagreeable to the taste.

In order to make a nourishing beef tea, a pound of tender, lean meat should be chopped fine and allowed to soak two or three hours in a pint of cold water. The vessel should then be heated on the stove (not to the boiling point), for two or three hours longer, until the water has evaporated to half a pint. If the meat be delicate and free from gristle and tendinous matter, and if it be not heated to the boiling point, there will be no scum to skim off of the top nor fibrous residue to remain on the bottom; but the mixture will consist of a brownish liquid, with brown flakes floating in it. When properly seasoned it is as delightful an article of food as can be presented to an invalid; and the maker will soon have a great reputation among the sick for her dainty dishes.

We cannot believe that the preparation, thus described, served unstrained does not contain the strength of the meat. The nourishing elements of the meat surely do not evaporate, and they are neither skimmed away, nor left behind in the vessel. Where else, then, can they go, except into the stomach of the invalid?

We admit that some invalids cannot digest the brown flakes of the tea, which produces relaxation of the bowels. But such persons could probably not digest the casein of milk either; as in certain cases of typhoid fever. When, however, the stomach and intestines have any digestive power at all, we would recommend the preparation above described as an alternative for milk. A sick person can in this form take a pound or more of beef in 24 hours, if there be no relaxation of the bowels, such as sometimes follows the use of all soup preparations. The various modifications of this method, such as heating the meat with little or no water in a bottle, are good; but the method given is perhaps the most elegant. The main points are to use lean, tender beef, to soak it for hours in cold water and *on no account to bring it to the boiling point* in the final slow heating.

Medical Progress.

## NOTES FROM A LEPER HOSPITAL IN NORWAY.

A correspondent to the *Nashville Jour. of Med. and Surg.* writes of a visit to the hospital in Bergen:

I was next shown the working room where those who could might pass their weary hours of waiting. Some were engaged in making shoes, others weaving, but most were employed with fish-nets.

There were a number of patients who had passed their 75th year. In the female ward I saw a married woman whose two young daughters were also inmates, and were with her. I saw one leper at the point of death—an old woman as white as snow, propped up in bed. Many of the women, those who retained any sense of touch, were knitting. Most of them seemed bashful and timid. One or two refused to show me their faces. I saw nearly all the patients; a few were in a garden enjoying the sun and fresh air. I was told that a few were cured, that is, the disease stopped, but there could not have been much left of them. The hospital was very clean and comfortable, but there was an odor that was almost unbearable at first, but I became accustomed to it in a short time.

There are now 109 patients there. Two years ago there were 200. I saw a number of them on the streets, who I suppose had been cured, for certainly they would not otherwise permit them to prowl around.

I have seen the Hospital for Spedalski, and spent half an hour in it, but I have no desire to go again. I was shown the chapel where they worship. This affected me as much as the patients themselves.

## ERUPTION OF THE DECIDUOUS TEETH, AND GENERAL SYMPTOMS.

H. Augustus Aldred, D. D. S., Philadelphia, in *Arch. of Pædriatics* (for Oct.), writes:

At about the fifth month after birth the process known as the eruption of the teeth begins; a double process, consisting of the gradual elongation and rising of the teeth, and the coincident absorption of the hard and soft tissues overlying them.

The alveolar borders are the first to show signs of the absorptive process, by a dissolution or melting of their approximated edges, thus gradually making a wider space for the advancing teeth. These rising in their sockets, the roots meanwhile lengthening, press upon the overlying gums, which, becoming thinner and thinner, finally allow the escape of the imprisoned teeth.

The symptoms of pathological dentition are loss of appetite, peevish fretfulness, wakefulness, feverish thirst, continuous suffering, bowels loose or constipated, tendency towards congestion of brain, and it may even terminate in death. The usual local signs of abnormal dentition are redness and swelling, followed by whiteness of gums, decided flow of saliva ("drooling"), desire to suck thumb or fingers, biting the ring or spoon with determination, alternately taking and refusing the breast, and desiring upright position (to counteract flow of blood).

The rule is that the lower teeth precede the upper of the same class two or three months, but not infrequently the upper precede the lower by the same difference in time. Again, the rule is that the teeth are erupted in pairs, with an interval between the different pairs, but occasionally a single tooth will appear a considerable time before its fellow, and in other cases two or three pairs will erupt coincidentally. The deciduous or temporary set of teeth are twenty in number. The usual order of their eruption is as follows:

Central incisors, lower, 5 to 7 months; upper, 7 to 8 months; lateral incisors, lower, 8 to 9 months; upper, 9 to 10 months; first molars, lower, 11 to 12 months; upper, 13 to 14 months; canines or cuspids, lower, 17 to 18 months; upper, 19 to 20 months; second molars, 23 to 30 months.

#### ALBUMINURIA.

In an extensive article upon this subject (*Lancet*, December 12, 1891), Dr. Fox classifies his cases as follows:

I. *Albuminuria of renal disease*.—In these the albumen was sometimes in large amount, enough to measure, and was associated with other signs of kidney disorder, such as deposit of pus or blood cells, casts or renal epithelium, cardiovascular degeneration, anæmia, œdema, with perhaps a personal or family history of gouty or kidney trouble.

II. *Permanent albuminorrhœa*.—A professional man, aged thirty-one years, came for examination, telling me he had lately been unconditionally declined by a well-known company. He had an excellent record both of family and personal history, and had never been ill since early childhood (scarlatina at the age of three years). He was ruddy, well-nourished, in the active enjoyment of life, and believed himself to be perfectly well. His heart and lungs appeared quite sound, and the only flaw was the presence of much albumen in the urine—a precipitate of  $\frac{1}{4}$  in depth, later 1.2 per cent., by Esbach. The urine, of which I saw several specimens, had a specific gravity of 1015 to 1024, no sugar, and no organic deposit visible, nor did the amount of albumen vary at different times in the day. I could find no cause for the albumen, and he was candid and straightforward in all his replies. He was clearly uninsurable, but I thought that after a year's interval he might be taken as a life of special risk. He did not, however, apply again, being tired of companies and doctors, but I had an opportunity over two years later of again thoroughly examining him. He was now married. His health continued excellent. I ascertained that the retinæ were healthy, whilst the urine was in precisely the same condition, excepting that I now succeeded in discovering a number of small casts, mostly hyaline. With this case I would mention one seen in private—a stout gentleman, aged sixty years, of active habits, but out of business. He has lived somewhat freely. His urine seems to have contained albumen for many years past, without apparent derangement of health. When he consulted me, two years and a half ago; and on each occasion since, there was a dense cloud of albumen, 0.6 to 1.0 per cent. (Esbach); sp. gr. 1015 to 1023; hyaline casts sometimes present in good numbers. The albumen was, he said, discovered seventeen years ago, and the urine had been tested a few times since, and found sometimes albuminous, sometimes not. He has no increase of vascular tension, nor has he had any acute illness until last spring, when influenza and severe bronchitis kept him to his bed for the first time in his life; at the close the urine was unchanged. The hypothesis of a local scar in one kidney, resulting from damage long ago, might explain such a case. It may be that progressive kidney disease will eventually come on, but many years of health may be enjoyed in the interval.

III. *Albuminuria of loaded urine*.—In some of these cases the urine contained crystals of uric acid or oxalate of lime at the time of passing. A young man, aged twenty-one years, came for life examination with a history of several attacks of paroxysmal pain in one loin. I found his general health excellent, but a cloud of albumen and some blood discs in the urine, with large oxalate crystals. He was remitted for treatment, and a few weeks later had quite lost his oxalates and his albumen. Abundant uric acid crystals appeared in other instances to

play a like part. In other cases the urine was simply concentrated, specific gravity 1020 up to near 1040, over acid and pigmented, and generally depositing oxalates or uric crystals later on. Such concentrated urine is very common in confined city life, perhaps especially in persons with gouty family histories, but mainly where muscular and lung exercise do not bear proper relation to the ingestion of food. I suppose the albumen to be due to irritation of the kidney structures by the acid matters, sometimes perhaps mechanically by the crystals.

IV. *Albuminuria of unstable circulation*.—A large and important class. A trace or thin cloud of albumen was present, without necessarily concentration of urine, but coincident with circulatory disturbance. In such subjects there is an excitable heart, the apex beat generally low, the impulse exaggerated under examination, the action rapid, and often there is a hæmic systolic bruit heard at the left edge of the sternum, or at the apex itself. In two or three cases partial syncope came on during examination. There seems to be a loosely built circulatory apparatus, with variations of blood tension, both general and local; the pulse is often compressible; the urine is often deficient in acidity. Functional albuminuria, if the term be allowed, appears to me to consist mainly of the two classes now described—viz., 1, of loaded urine, and 2, of unstable circulation and varying tension; and in both these classes, especially the latter, the albuminuria is often cyclic.

*Albuminuria of adolescence* was attributed to the practice of certain bad habits. Such habits tend to produce palpitation and circulatory instability, and probably in this way cause the albuminuria; but it may be doubted whether this causation accounts for more than a small portion of the large class referred to.

*Albuminuria from hepatic disorder*.—A retired Indian officer, with old liver damage, showed a small trace of albumen in the urine, for which no other cause could be found. Dr. Dickinson alludes to this form of albuminuria.

*Accidental albuminuria*.—I pass to a further division of the subject, to those instances in which albumen appears from accidental causes, transient in their operation, having little bearing on the prognosis of life, and, therefore, unimportant for insurance purposes, yet their detection and recognition are of much consequence.

V. *Toxic albuminuria*.—Here the cause has reference to articles of food, drugs, or poisons. 1. A healthy man of thirty-five came before me a few days ago, with a decided trace of albumen in his urine. There were neither concentration of urine, over-acidity, disturbed cardiac action, nor any other cause apparent. But I learnt that he had taken, shortly before, a meal of three eggs, to which he was quite unaccustomed. The urine passed next morning was quite free from albumen; and its presence on the previous day may be probably assigned to the special albuminous diet. 2. Three tea-tasters appear on my notes as showing traces of albumen, in each case after a morning spent in tasting fifty, a hundred, or more samples of tea. In two cases I was able to ascertain that the early morning urine was practically free from albumen. 3. A robust young man aged twenty-four, an athlete, showed a marked trace of albumen in his urine. This was, perhaps, urethral in origin, as he had had gonorrhœa, but he himself ascribes it to a seidlitz dose taken the day before in preparation for a swimming match. And he told me that the clerks in a certain leading bank in London, when they want a holiday, take a stiff seidlitz, followed by a glass of brown sherry in the afternoon, and then go before the doctor to be invalidated for disordered kidneys. 4. A manufacturer aged twenty-nine, apparently in very good health, voided urine showing a marked cloud of albumen on boiling.

Nothing appeared to throw light on its causation, except that he had at the time a headache from exposure to the fumes of a new stove in his office. The urine early next morning was free. 5. Several cases have come before me which suggested the direct action of alcohol as a cause of albuminuria. Some of these may properly be referred to the heading of "hepatic albuminuria."

VI. *Albuminuria of strain or shock*.—Severe muscular exercises, headwork as at examinations, or the shock of cold to the surface in bathing, are here the factors at work.

VII. *Vesical, urethral, and vaginal albuminuria*.—Here the albumen is due to slight catarrh of the bladder, or of the urethra, as in gleet, or, in women, to leucorrhœa. Traces of albumen from these causes are, I believe, common, and are apt to vitiate our tests in insurance cases, unless carefully excluded. Proof is difficult in such instances, but cases I have observed in private have convinced me of the facts. In bladder catarrh, mucus and mucus corpuscles will be in excess; in gleet and leucorrhœa, much squamous epithelium. The great frequency of leucorrhœa (much or little) renders it difficult to obtain reliable results as to albuminuria in women; I seldom examine female urine without finding at least a trace of albumen present.

A final category must include seventeen cases in which the albumen was unexplained; in most of these a mere trace was present. Probably nearly all of these cases could, with fuller knowledge, be assigned to one of the classes above stated.

#### AINHUM.

Dr. von Winckler, of the British Guiana Medical Service, has reported finding twenty cases of the disease known as ainhum amongst the out-patients at the public hospital Georgetown. Ainhum may be defined as a condition in which the spontaneous separation of the fifth toe occurs. Nineteen of the cases were blacks, either Africans or of African descent, and only one was an East African immigrant. They were all males. The average age was between thirty and thirty-five years, but one case was in a man aged fifty, and in another the advanced age of seventy was given. One patient only followed a definite trade, that of a carpenter; the others were laborers or porters. There was no evidence of heredity to be found. In all cases the fifth toe was involved, in two cases both fifth toes, and in one case (that of the carpenter) both fifth and fourth toes of the right foot. In the majority of cases the seat of the disease was in the skin fold which corresponds to the inter-phalangeal joint, and in a few cases it was in the fold over the metatarso-phalangeal joint; in no case was it seen as beginning at the base of the unguis phalanx. The appearance has been well described as like that due to ligature applied tightly round the toe and eating its way through, giving the toe a characteristic bulbous end. There was a marked absence of any sign of syphilis or leprosy in the cases, and no definite account of any injury was obtained. None of the cases gave an early history of pain; there were no subjective symptoms till an advanced age of the disease had been reached, when ulceration commenced, and acute pains, with burning, were complained of. It was at this stage of the disease that all cases came to seek advice who applied for treatment for this complaint. The duration varied considerably, the shortest time being nine months and the longest five years. An average of from two to three years was the duration of the majority of cases. Microscopically, there was hyperplasia of the fibrous tissues of the skin, together with fatty change. The artery was much thickened, the intima being more especially involved—a condition of endarteritis. In the bone the condition resembled that of rarefying osteitis. As



to treatment, this seemed to resolve itself into removal. Of the twenty cases seen, only four would allow the toe to be removed. The remainder were treated in the out-door department with some simple dressing, as they preferred to allow the amputation to be done by nature. As to the causation of this condition nothing definite is known, and Dr. von Winckler has failed to discover anything that can be looked upon as its absolute cause; it may be of parasitic origin. There would seem to be a marked racial influence, for he has not seen it in any but the dark-skinned races. He does not think it can be due to the effect of wearing rings on the toes, for this is much more frequently done by the coolies, and more especially by the coolie women; yet none of the cases were in women. Further, in none of the twenty cases had rings ever been worn on the fifth toe.—*Lancet*.

#### THE ELECTRIC CURRENT FOR UTERINE HÆMORRHAGE.

From a more extensive article on this subject by Dr. Hayd (*Med. Record*, Dec. 19), we clip the following:

In the treatment of hæmorrhage we must endeavor, as far as possible, to find the cause, in order to bring about such a condition of the body as will lessen any tendency to blood stasis. In a general way we may say, the more the bleeding is due to local causes the more likely will it be controlled by local measures. If anæmia, with its consequent loss of tone and a generally relaxed condition of the system, be the principal causative feature, tonics in the shape of iron—especially the tincture of the chloride—arsenic, and an abundance of good nourishing food, and outdoor exercise, and brisk dry rubbing, or even a daily cold sponge-bath, if borne, will be indicated. Occasionally plethora may be responsible, and if so, it is best met by brisk saline cathartics, a simple but nutritious diet, and active exercise, especially walking, and regular systematic gymnastics. If obstructive causes in remote organs be present, as valvular heart lesions, lung, kidney, or liver complications, etc., such general measures should be employed as would naturally be suggested. However, uterine hæmorrhage, either as menorrhagia or metrorrhagia, is more often the result of local disease in the uterus or its appendages, and will be satisfactorily controlled by relieving or curing the diseased conditions which produce it.

In recent subinvolution following abortion, where slight hæmorrhage continues for days and even weeks, due to a want of tonic contractility in the uterine muscle fibre, vaginal faradization every day, or every other day, will be found eminently satisfactory. The use of ergot, even in large doses, alone or combined with other uterine stimulants, is often not sufficient to control this condition, and there soon results from a simple inertia a possible chronic subinvolution with fungous endometritis, salpingitis, and all their attending complications. Moreover, after too frequent child-bearing, or in conditions of debility accompanying recent parturition, when the womb lacks its proper contractile power, and as a result absorption and involution are impeded, the faradic current combined with general tonic treatment will give the most gratifying results.

Mrs. F——, aged thirty-four; second confinement; first, nine years ago. Labor satisfactory and no special hæmorrhage. Physical condition much below par; extremely debilitated, thin and emaciated from the exhausting vomiting, which persisted during the greater part of uterogestation. Slight bleeding persisted for three weeks, notwithstanding rest in bed during the whole period, regular and systematic applications of the child to the breast, injections of very hot water, and the administration of ergot, and good, easily digested food. Vaginal faradism was employed, with the effect of at once stopping the hæmorrhage, increasing the tone of the vagina and uterus, and bringing about constant and continu-

ous contractions, which resulted in a satisfactory involution. The patient was permitted to get up, and by the end of the fourth week could walk with comfort. The womb was in good position, of course heavy and enlarged, and there existed but very little leucorrhœa. The applications were continued for one month, and were made by the patient herself every day, the *séance* lasting about seven minutes, the strength of the current estimated by her own feelings, and as much was taken as could be conveniently borne. The bowels became regular, the appetite improved. The general condition was satisfactory, and the woman made an excellent recovery.

Hæmorrhage resulting from a fibroid tumor can usually be controlled by positive galvanism; at all events, the results have been so encouraging in my hands that I shall always first employ this treatment before resorting to other operative measures. Occasionally the faradic current is very useful in assisting the expulsion of a uterine polyp, so that an *écraseur* can be applied, and complete its delivery, as happened in one case under my care when profuse and exhausting hæmorrhages had existed for months.

#### RELATION OF ALBUMINURIA TO SURGICAL OPERATIONS.

In a paper upon this important theme read before the Southern Surgical and Gynæcological Association (*Virginia Med. Monthly*, Dec., 91) Dr. Long arrived at the following conclusions:

1. Ether or chloroform rarely injures healthy kidneys.
2. When renal disturbances occur from the use of an anæsthetic, the kidneys being healthy, they are due rather to prolonged narcosis, exposure of the patient, or perhaps to the combined influence of the operation and the anæsthetic.
3. A mild degree of albuminuria (or nephritis), especially if recent, is not a contra-indication to the use of chloroform.
4. Even in the presence of advanced and extensive renal changes, an anæsthetic may be employed, provided the patient or the family be advised of the additional risk.
5. Of the two anæsthetics usually employed, it is yet a mooted question as to which is the safer, so far as the kidneys are concerned, unless it be in obstetrical operations.
6. While it is by no means the rule, profound functional disturbance, and even organic lesions may be induced by an operation, apart from the influence of the anæsthetic.
7. Such renal changes are due to reflex sympathetic action, or to sepsis, or both.
8. Operations in certain regions—notably, the abdominal, genito-urinary, anal, or rectal, are especially liable to produce renal complications.
9. A healthy condition of the kidney *minimizes*, but does not obviate the danger referred to.
10. Albuminuria is always an indication of renal lesions, and should be regarded with distrust, but is not a positive contra-indication to an operation.
11. When albuminuria is associated with other evidences of advanced renal changes, no operation should be undertaken without candidly stating to the patient or friends the dangers incident to the condition of the kidneys.
12. Paradoxical as it may seem, an operation will sometimes relieve an albuminuria due to acute affections.
13. No surgeon is justified in undertaking an operation without first knowing the state of the patient's kidneys.

## SYSTEMIC INFECTION IN GONORRHOEA.

From an elaborate report in the *Virginia Med. Monthly*, December, 1891, of an article presented to the Southern Surgical and Gynæcological Association, we quote these paragraphs:

Dr. Bedford Brown, of Alexandria, Va., in his paper cites five cases of systemic infection from gonorrhœa. He believes that there are two channels for the absorption and transmission of the gonorrhœal microbe into the general system. One is by continuity of surface over the mucous membrane of the genito-urinary tract from the urethra to the kidney. The other channel is through the medium of the great lymphatic system from the lymphatics of the urethra to the inguinal glands; thence through the lymphatics of the system into the general circulation, though in a great majority of cases it does not extend further than the prostate or the inguinal glands. He believes also, that this microbe so transmitted is lodged at different points in the organism. The gonorrhœal microbe, transmitted by continuity of surface over the genito-urinary tract, invariably induces specific suppurative inflammation. On the contrary, when absorbed through the lymphatics, the inflammation is not of a suppurative character, but assumes peculiar types. Thus the contact of the infectious microbe with the mucous surfaces produces suppurative prostatitis, cystitis, ureteritis, pyelitis, then pyonephrosis. The absorption of the same through the lymphatic channels first sets up lymphangitis of the urethra, then lymphadenitis of Cowper's glands, then of the inguinal glands, then inflammation of the connecting lymphatics. Then, by further absorption, it induces septic phlebitis of the thigh, and finally synovitis and endocarditis and destructive ophthalmitis of the internal structures of the eye. He believes also that in certain cases genuine septicæmia may be developed in the course of these complications. He thinks that there is a marked relative difference in the susceptibility of different constitutions to the systemic poisoning of gonorrhœal infection. That the absorption and infection of the system from this cause is only in exceptional cases. The writer lays stress on gonorrhœal ureteritis following cystitis as a part of the action of the gonorrhœal infection in its travels over the mucous surface of the genito-urinary tract towards its final destination—the kidneys. This complication is accompanied with pain, at times sharp and paroxysmal, but usually dull and aching in character. These sharp paroxysms of pain extend upwards towards the kidney, and not down towards the bladder as in nephritic colic. Then, again, there is soreness in the entire line of the ureters, increased on pressure, so that the course of the ureter may be clearly marked out. Ureteritis always is established before nephritis begins in gonorrhœal infection. The cases cited by Dr. Bedford Brown indicate that a state of septicæmia may be developed by systemic infection in gonorrhœa in certain cases. Thus he has seen septic infections, gonorrhœal prostatitis, cystitis, endocarditis, pyonephrosis, lymphangitis and phlebitis. He is impressed with the conviction that gonorrhœal synovitis and endocarditis have no analogy to true rheumatism; that the gonorrhœal microbe, when once absorbed into the general system through the channel of the lymphatic system, assumes the character of a septic poison, and, when lodged in the tissues, is capable of arresting the process of nutrition in the part, of disturbing the process of metabolism, and establishing local inflammations of a peculiar type and progress. Most fortunately, it is only in rare instances that the systemic absorption occurs in the progress of ordinary gonorrhœa.

## SULPHURING OR BLEACHING OF DRIED FRUIT.

From an article upon this subject by Dr. Smith (*Canada Lancet*, Dec., 1891), we learn that it is about fifteen years since the sulphuring or bleaching of dried

fruit began. At first only the uniform light color was sought, as in apples, pears, etc., but for some years past nearly all the large evaporating establishments have "sulphured" all kinds of fruits and some vegetables, and now much of the California sun-dried fruit for market is also treated in the same manner. The light color, especially of apples, early attracted unthinking consumers and commercial men, thus materially increasing the price of such fruit. That caused the practice to spread even to those who disapproved of it. The expense and trouble were very slight. Fruit so treated is said to dry more readily, consequently all now prefer to do it.

While the apparent change is only in color, there is a loss of the natural fruit flavor, even by the most careful sulphuring. Unfortunately, some people do not notice the difference, but careful comparison shows it, as is admitted by the manufacturers of such fruit.

The practice began in California with apricots, as early as 1879. At the Twelfth State Fruit Growers' Convention, held in Fresno during four days in November, 1889, a paper on "Fruit Drying" was read by J. L. Mosher, of San Jose, and in his paper he remarked: "If fruit be picked before ripe and over-sulphured to produce whiteness, it is devoid of its true rich taste and flavor and *only requires polishing to make buttons.*" (The italics are his.) In discussing the paper, one gentleman said: "I believe sulphuring the fruit is the greatest mistake in the world. I do it, but I believe it is wrong; the flavor of the fruit is gone after it is sulphured."

This change in quality was the first thing that called the attention of the writer's family to what was lacking in the "nice, uniformly colored" bleached fruits.

Later investigations have proved the presence of sulphate of zinc, "white vitrol," in all samples of fruit where zinc surfaced trays were used to hold the sulphured fruit while drying. Interested parties have charged the German prohibition of American evaporated apples to rival trade opposition, but there is no German fruit to compete with them. The real cause was the finding of zinc poison in considerable quantity.

#### MEDIASTINO-PERICARDITIS.

At a recent session of the Manchester Medical Society, Dr. Harris (*Lancet*, Dec. 12, 1891), exhibited a preparation of chronic mediastino-pericarditis from a boy fourteen years of age. The illness terminated fatally in about eighteen months from the time of the first onset of symptoms. The boy had been under Dr. Harris's observation for about fifteen months. When first seen he had much dyspnœa, especially on exertion, and the lips were very blue. The veins of the neck were full, but there was no inspiratory distension of those vessels. The pulse was 120, small, and the sphygmographic tracings showed a well-marked pulsus paradoxus. The heart sounds were feeble, but unaccompanied by murmur. There was decided dulness over the sternum, from the base of the heart as far as the second costal cartilages; there was also considerable pleuritic effusion at both bases, more marked on the left side. The liver was enlarged, but there was no ascites or anasarca. After repeated aspirations of the pleuritic effusion the boy improved; but a few weeks before his death ascites and anasarca appeared, with signs of catarrhal pneumonia and bronchitis, the pulse became extremely feeble and he died about eighteen months from the first onset of the symptoms. At the onset of the illness the medical attendant diagnosed acute pericarditis and acute pneumonia. The necropsy showed the presence of a large mass of fibrous tissue in the mediastinum, and in the centre of this a large caseous-looking mass which extended from the sternum in front to the tracheæ

behind. Microscopical examination of this mass gave no evidence of it being tubercular. The pericardium was everywhere adherent. Liver enlarged, and microscopical examination showed marked venous congestion without any portal cirrhosis. There was no evidence of tubercle in any organ.

### Medical Items.

A Faculty of Medicine is about to be established in Constantinople.

Mr. Jonathan Hutchinson, of London, England, has a poor opinion of the administration of arsenic for skin disease in elderly persons and seldom prescribes it for such.

A student of pharmacy in Hesse was called upon to put up a prescription containing a twenty per cent. solution of chromic acid, salicylic acid and water. He put the crystals of chromic acid directly into the alcohol, whereupon an explosion took place, and the unfortunate student was severely burned in the eyes.

To empty at once a distended bladder, is to expose the patient to the danger of a vesical hæmorrhage; it is necessary to desist as soon as the urine does not escape in a jet, but falls in dribblets, drop by drop.

A Philadelphia man is enthusiastic over the efficacy of advertising. The day after he had inserted in a paper a notice saying that he wanted a boy, his wife presented him with twins, both boys.

A new society, to be known as the Western Association of Obstetricians and Gynæcologists, will come into existence soon. Geographically, its territory will include the Missouri river, cities of Iowa and Missouri, and the states and territories of Kansas, Nebraska, Colorado, New Mexico, Indian Territory and Oklahoma.

Dr. Variot has discovered a new process, and which he calls "Galvanic Anthroplastic," by which the cadaver can be thoroughly metallized. According to the wishes of the friends and relatives (and the depth of their bank account) the body can be surrounded with a nickel, bronze, silver, or gold envelope.

A Russian writer recommends the flowers of the red rose as a remedy for the treatment of chronic diarrhœa. It is a favorite home remedy for this trouble among the Russian people. A handful of the dried flowers is made into an infusion. Children up to 5 years of age take a tumbler of the infusion in the course of a day. Adults may take from two to three tumblerfuls. Its taste is agreeable, especially if some sugar be added. It has cured some obstinate cases of diarrhœa in less than a week.

A New Orleans milkman who has been fined for watering milk protests that without water the fluid could never be transported over the rough streets in warm weather without churning. The Louisiana dairymen must keep a better breed of cows than that which supplies this city with milk.

An interesting reproduction of Benjamin Franklin's historical experiment with the kite, under somewhat different conditions, has been carried out at the Blue Hill Observatory by Alexander McAdie. What Mr. McAdie has demonstrated is that electricity can be drawn from a kite high in the air in a cloudless sky. The kite discharged sparks from the lower end of an insulated wire reaching down to the earth, where an electrometer partly measured the increas-

ing electric force. So nearly did the quantity of electricity in the upper air correspond to the height of the kite above the earth that the experimenter could usually determine whether the kite was rising or falling by simply looking at the needle of the electrometer.—*American Druggist*.

With the opening of the new volume of the *Journal of Cutaneous and Genito-Urinary Diseases* for 1892, Dr. John A. Fordyce, who has been actively associated in the management of the journal for the past three years, will assume the sole editorial control. No change will be made in the publication department, and no effort or expense will be spared by the editor and publishers to maintain the high standard of scientific and artistic excellence which has distinguished the journal in the past.

The greater part of the ambergris sold in London during the last few years has been obtained by the New Zealand and Tasmanian whalers who ply their trade in the Antarctic Ocean. Whale-fishing was once an important industry in Tasmania, and quite a large fleet of whalers was owned by Hobart firms. Now the Tasmania industry has practically ceased to exist, and there is no hope of its revival. New Zealand still possesses fisheries of some importance, and will probably continue to supply our market with much of its ambergris for many years to come. Meanwhile spermaceti whales are getting scarcer year by year, and the time may soon come when the scarcity of ambergris shall be chronic instead of spasmodic. It is to be hoped that, before that date, science will have taught us how to supplant nature in the production of ambergris; but at present there are no indications whatever of an efficient synthetic substitute.

Cousin Jonathan, says the *British Medical Journal*, having suddenly awaked to the fact that the United States was being used as a dust-heap for human rubbish from the Old World, a few years ago established a system of "sifting" intended to exclude all emigrants who, owing to disease or other causes, did not seem likely to add to the greatest happiness of the greatest number in the country in which they meant to begin life anew. During the last seven years one thousand three hundred and seventy-four lunatics and diseased persons have been sent back to Europe from the State of New York. A complaint is now beginning to make itself heard that the sanitary sieve allows many of the unfit to pass, to the detriment of the general health of the Republic and of the physical perfection of its future citizens. Medical practitioners have, it is stated, occasion to know that only a small percentage of the diseased and undesirable emigrants are returned to their homes. One-third of the insane in the United States, and over one-half of the dispensary and hospital patients, are said to be foreign-born.

An Army Medical Board will be in session in Chicago, Ill., during February, 1892, for the examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before January 15, 1892, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they are graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidates must be between 21 and 28 years of age, and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the Board. Further information regarding the examinations may be obtained by addressing C. Sutherland, Surgeon General U. S. Army, Washington, D. C.

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## CONTENTS

### ORIGINAL ARTICLES.

A Case of Elephantiasis Scroti. By Randolph Winslow, M. D., Baltimore. . . . . 221

On the Principles of the Treatment of Uterine Displacements. By Henry Banga, M. D., of Chicago. . . . . 223

### SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held Dec. 4, 1891. Thirty-Two Unselected Abdominal Sections. Treatment of Five Cases of Malarial Fever at the Johns Hopkins Hospital with Methylene Blue. Cholesteatoma, or Pearl Tumor of the Ear. . . . . 228

### EDITORIAL.

The Era of the Pessary. . . . . 233  
The Need of Training for Abdominal Surgery . 234

### OBITUARY.

Professor Francis Donaldson. . . . . 236

### MEDICAL PROGRESS.

Treatment of Insomnia with Drugs.—Bloodletting for the Relief of Cerebral Congestion following Influenza.—The Growth of Fibroids after the Menopause. . . . . 238

MEDICAL ITEMS. . . . . 241

## Original Articles.

### A CASE OF ELEPHANTIASIS SCROTI.†

BY RANDOLPH WINSLOW, M. D.,

Professor of Anatomy and Clinical Surgery, University of Maryland School of Medicine,

On September 7th, 1891, John Chandler, colored, aged 44 years, was admitted to University Hospital, on account of an enlargement of the scrotum and perineum. His father died of meningitis and his mother of phthisis. The patient is one of seven children, six of whom died of phthisis. He had measles in childhood, typhoid fever at the age of 21, and gonorrhœa about eight years ago. He has no recollection of having had any other disease. The present disease began about three years ago, with slight thickening of the tissues of the scrotum, penis and perineum, the infiltration first showing itself in the skin of the scrotum and increasing slowly, until at the time of his admission the scrotum was enormously enlarged, and reached  $\frac{1}{3}$  of the distance to the knee. There were a number of suppurating sinuses, and superficial abscesses in the scrotum and perineum. There was some pain, but the chief cause why he sought treatment was that he was incapacitated from following his occupation. The tissues of the scrotum were brawny, and very little impression could be made on them by pressure; the perineum was composed of similar tissue and was enormously hypertrophied. The skin of the penis was also thickened, but retained its suppleness, and the prepuce could be easily retracted. The penis itself was somewhat lost

†Read at the Semi-Annual Meeting of the Medical and Chirurgical Faculty of Maryland, Nov. 18th, 1891.

in the scrotum. According to his own statement his virile powers were unimpaired. By occupation he was a sailor, but he had never been much beyond the coast of this country, and had never resided in a tropical country. He was born in Virginia, and had for most of his life sailed on the Chesapeake Bay.

The diagnosis of elephantiasis was made. Several efforts were made to detect the *filaria sanguinis hominis* by examination of the blood, but without success. The parasite did not appear to be present.

The sinuses were incised, and a long incision was made in the perineum, in order to relieve tension, and allow the lymph and blood vessels to empty themselves. In addition, he was placed on iodide of potassium, as syphilis could not be excluded. His condition did not improve, and excision was proposed, and declined, as he was under the impression that his testicles would have to be sacrificed. After several weeks of unavailing treatment, and the assurance that every effort would be made to save the testicles, he consented to excision of the scrotum, which was performed on October 1st.

The parts had been cleansed, shaved and disinfected over-night, and the whole scrotum and perineal hypertrophy were excised, the skin being dissected up from the underlying tissues. The skin and subcutaneous tissues were very dense and thick, and freely supplied with blood vessels. The bleeding points were caught as divided, and no excessive hæmorrhage occurred. The testicles were carefully dissected out, and were uninjured. The gap in the perineum was closed with sutures, but there was not sufficient tissue to cover the testicles, hence lateral incisions were made in the contiguous skin and strips of skin dissected up and brought over so as to form a new scrotum. The tension was so great, however, that the stitches cut out, and the flaps separated considerably. Healing was effected under about five dressings, and he was discharged well on November 8th, relieved of pain and discomfort and ready again to resume his ordinary avocations. Considering the amount of mutilation which was inflicted upon his organs, the result was eminently satisfactory both to me and to the patient.

Elephantiasis is a rare affection in this portion of the United States, though it occurs more frequently in our Southern States. It is frequent in the West Indies, South America, Egypt, Syria, India, China and Japan. We allude here to the elephantiasis Arabum, or Barbadoes leg, and not to the elephantiasis Græcorum, or true leprosy. It affects by preference the legs and genital organs of both sexes, but occurs more frequently in males than in females. The scrotum is a favorite seat of the disease, and it often attains enormous bulk, weighing in some instances 40, 50, or even 100 pounds. In one case which was removed by the French surgeon Delpech, the tumor weighed 160 pounds. In the female the labium majus or the clitoris sometimes become affected in a similar manner, producing large pudendal growths. Only a few days before the case narrated above entered hospital, a young woman was discovered in one of my wards with a dense, brawny hypertrophy of the right labium, which, in external characteristics at least, resembled the disease in question. There is usually some preceding inflammation, with local enlargement, œdema and tenderness, the swelling gradually increasing until a condition of brawny thickening of the subcutaneous connective tissue remains permanently, the skin also being thickened and thrown into folds with intervening fissures. Superficial ulcerations are also likely to occur. The subcutaneous connective tissue is enormously increased both in quantity and density, so that it is white and hard, cutting almost like cartilage. The lymph spaces are dilated and the veins enlarged and tortuous,



making the operation for the removal of the growth very bloody. When the tumor is very large the penis usually drawn into the growth, and must be removed with it, unless it can be dissected out. The testicles are usually sound, but are so hidden in the tumor as to render their preservation difficult in all cases, and impossible when the tumors large. The disease is supposed to be due to an obstruction of the lymph channels. Sometimes the *filaria sanguinis hominis* is found in the blood and is supposed to be the cause of the disease.

*Treatment.*—But little relief can be placed upon the administration of drugs either to remove or arrest the disease, and the condition usually progresses continuously until it is removed by the knife. When the tumor by its bulk seriously interferes with the comfort of the patient it must be excised. When the growth is large its removal is fraught with great danger, and many patients have died on the table or shortly after the completion of the operation.

Mr. Wilks is said to have had a case before the completion of the operation, which had been nearly eight hours on the table; the tumor having been nearly six feet in circumference.

Dr. Esdaile, of Calcutta, operated 161 times with a mortality of only 5 per cent., and Dr. Ballinghall of Bombay, 21 times with two deaths. Hæmorrhage is more under control now than formerly, and by the use of the elastic bandage and hæmostatic forceps the operation is deprived of many of its terrors. In elephantiasis of the lower extremity, good results have followed the ligation of the femoral artery, a method introduced and practiced by the late Dr. Carnochan, of New York, and repeated by Bryant, of London, and others. Dr. Thomas G. Morton, of Philadelphia, in one case excised a portion of the great sciatic nerve, with marked lessening of the size of the limb.

ON THE PRINCIPLES OF THE TREATMENT OF UTERINE DISPLACEMENTS.†

HENRY BANGA, M. D., CHICAGO.

It is evident that the best method of treatment in prolapse of the uterus should undoubtedly be the reduction of the womb to its former position as nearly as possible. How this may be accomplished is not the subject of this paper. I might, however, state that in younger persons, still in the child-bearing age, pessaries are valuable as a temporary measure. A time will, however, arrive when no instrument will retain the prolapse, and operation has to be resorted to. Also, in older persons, when for any reason an operation seems not feasible, pessaries are valuable. I consider an operation upon the vagina to answer well enough for prolapse cases, leaving Thure Brandt's method of uterine massage, ventro-fixation or hysterectomy to special indications.

Anteflexion and retroflexion are the two varieties of displacement upon the part which gynecologists widely differ. There are two diametrically opposed methods of handling such cases. The one, which may be called the mechanical method, is based upon the theory that the position of the uterus is the chief cause of the complicated and diversified symptoms, and tries to bring the uterus back to its normal position, principally by means of pessaries; while the other entirely ignores the displacements as such, except in a few well-marked cases, and seeks the explanation of the symptoms in other directions. My experience leads me to adopt the latter view. This view finds its sup-

†Read before the Anatomical Society of Chicago. For the portion of the article which deals with the symptoms, the reader is referred to the *Amer. Jour. of Obstetrics*, January, 1892.

port in the fact, accepted by everybody, that there are no pathognomonic symptoms of ante- and retro-flexion, and that almost every symptom enumerated by the text-books may be explained also in some other way. It is the object of my paper to show what results may be obtained by applying this principle in our practice.

Whenever I take charge of a case of ante- or retroflexion, I make a thorough examination of the pelvic organs, often under æsthesia. Such an examination informs me as to the real position of the womb and the cause of its deviation, if present. The displacement, as such, I first entirely disregard. Any inflammatory process about the genital canal, however, treated according to generally adopted principles, the chief feature of such treatment being rest, disinfection, and free discharge of retained pus or mucous secretion. This amounts practically to frequent dilatation of the cervical canal, and washing out of the uterine cavity, and intra-uterine application of some disinfectant or astringent. In some cases it appears evident that removal of a diseased ovary or oophorectomy also, in a few instances, is indicated to preserve her health. Trachelorrhaphy also, in a few instances, is indicated to prevent discharge in congestion of the womb. I then turn to the subjective symptoms of the patient. Among these, bladder trouble takes a foremost place. I do not believe that pressure of the uterus upon the bladder causes frequent micturition, burning and tenesmus, I closely inspect the vulva, and hardly ever find something to account for these symptoms, such as urethral caruncule, vulvitis, gonorrhœal or mechanical (masturbation), spreading to the urethra or bladder. I always draw the patient's urine, and often find evidence of cystitis or gravel. I am surprised how often bladder trouble in women is due to gravel. This may be due to our Chicago water. Such urine contains more or less crystals of uric acid or phosphates, causing mechanical irritation from their sharp edges while passing through the urethra.

Sometimes patients imagine that they pass "blood" with the most excruciating pains, whereas in fact the appearance of blood is due to nothing else than the abundance of uric acid crystals. The urine may be quite clear until we pour it in a glass and hold it up against the light, when the glittering crystals are recognized at once. Free drinking of water will relieve the burning micturition and tenesmus in a few hours, thus corroborating the diagnosis of gravel. The next most frequent complaint is constipation. How many women are in this respect is shown by the statement that eighty per cent of so-called female complaints directly depend on constipation. My chief aim is to impress upon the minds of the patients that by regular attention to this matter they will sooner or later cause the bowels to move in the most satisfactory manner. Flatulency will disappear when the bowels begin to move regularly, and when the patient is taught to avoid or to restrict the use of gaseous foods, to eat regularly, and to masticate her food well. Manual housework, out-door exercise (such as shopping or marketing), will assist proper action of the bowels, will strengthen the muscles, especially those of the abdomen and the perineum, will increase the appetite and bring back a feeling of strength and improvement. The mind will be brightened, nervousness, cold feet, rushes of blood to the head, sleeplessness, and the feeling of fatigue, will disappear. Amongst the better classes, early rising, walking, and cold baths, and filling out an otherwise lazy, aimless life with some sensible occupation, will especially have a wonderful effect upon the nerves and general system. In the course of several weeks or months the patient may be justly credited while her uterus still remains in an anteflexed or retroflexed position, as may be.

I will admit that the cure of such a patient will be accomplished in this way only upon the conditions that you are the first physician to treat her, that you show a great deal of patience in repeating the same directions over and over again, that she herself learns to understand the meaning of your orders, and that you do not mention the displacement at all. It is a queer fact that so many women will refer almost all their ailments to the womb. Any stomachache, any backache or headache, is a sure sign of womb trouble. A slight miss-step, working on a sewing-machine, lifting a window sash, or carrying a child oftentimes causes something inside to give way suddenly. Her friends tell her that the womb no doubt has turned, that the ligaments have become overstretched, and the like. She will soon see a physician, who corroborates her own notions by telling her that her womb was really out of place, but that he would lift it back again, and would prevent it from slipping out of place by an instrument. From that moment on the woman becomes a regular crank. Those are the innumerable patients that give the ordinary practitioner so much trouble; that go from one office to another, from one dispensary to another; who will submit to any effort to bring the poor womb back to its imaginary normal position. They are the ones who suffer unnecessary pains and incur the expense of constant doctoring, and contract once in a while a severe attack of peritonitis from a too large pessary pressing on and injuring a prolapsed ovary or tube. This condition of affairs is a real disgrace to the profession, the more so since a majority of such cases are either girls, or young women who are anxious to become pregnant. We all know what misery pelvic inflammation is capable of bringing to a woman, yet every one of us has seen cases where such a complication directly followed the use of a pessary.

In order to substantiate my statements, I present the history of a few cases.

Six years ago a young country lady of 19 was brought to the Michael Reese Hospital in a wretched state of health. She was extremely anæmic and emaciated; had no appetite, no natural action of the bowels, and no sleep; her body was in a constant tremor, and she had been unable to leave her bed. Her history was as follows: Some five months previous, while enjoying perfect health, she went to see an oculist for a slight eye trouble. He told her that there was not much the matter with the eye, that she was nervous, and that probably the womb might have something to do with it. Now, mind that up to this time she hardly knew that she had a womb. However, soon after, upon the suggestion of her mother and elder friends, the family physician was asked to make an examination. He found the os within an inch of the introitus, the fundus pointing backward, and diagnosed falling of the womb. From that time on frequent efforts were made to raise the womb digitally, and to keep it in place by a variety of pessaries. Consultants were called in from Chicago, who also found the falling of the womb to require a new pessary. All this treatment was kept up in spite of the patient's general health daily growing worse and her nervous system becoming totally upset. The late Dr. Byford saw the patient with me. We found the vagina remarkably short, the cervical portion elongated so that it was felt hardly an inch beyond the hymen, the fundus turned straight backward, everything raw, tender and congested, but no cellulitis. We both were of the opinion that the use of the pessary and the frequent examinations in knee-elbow position were the direct cause of the poor girl's pitiful condition. All local treatment was discontinued at once, the case being managed only on general principles. The subsequent perfect cure demonstrated the correctness of this view. By the way, it seems impossible that this low position of the uterus, due

to shortness of the vagina and elongation of the cervical portion, could be mistaken for falling of the womb, yet I remember two more such cases, where I removed a pessary intended to support a prolapse which did not exist.

It is not always easy to convince a patient who has been used to a pessary to remove it and to try to get relief from her symptoms by the common-sense treatment outlined above. Here is such a case: Three years ago a lady called at my office and requested me to look after a pessary which had of late begun to be uncomfortable. She was a healthy-looking, strongly-built woman of 45, who had had four children, the last some eight years previously. Since that last childbirth she had "womb trouble" which necessitated the wearing of a pessary. A year ago she went to Germany, and, *en passant*, she consulted a leading gynecologist. His diagnosis was retroflexion requiring correction and another pessary. The patient went to his clinic and was kept lying on her stomach for five weeks; wood packings were used every other day; frequent bimanual lifting of the womb was practised, and different pessaries were tried. She endured torture, as she said, but was finally sent to a watering place, where she slowly recovered. It did not occur to her that no doubt the recovery at the bathing place was principally due to the cessation of those attempts at raising an exceedingly freely movable uterus. I removed a large Hodge pessary, and found a retroverted and slightly retroflexed uterus, freely movable, and with its cavity over three inches deep. I told the lady she might do without the pessary, if she would stop the daily injections with hot water; for in my experience I have found that frequent douches with large quantities of hot water keep the womb irritated and congested, and also excite the patient's nervous system in a general way. I also told her to educate her bowels to a regular movement every day, and to continue the daily walks she had become so fond of at the watering place. At first she would not listen to my suggestions; she insisted that she was told to always wear the instrument, and that she knew she would be miserable without it. After much talking, she finally left, rather disgusted, but with her Hodge pessary wrapped up in paper. I really thought she would find somebody, before returning home, who would put back the instrument. Two years afterwards, however, she again called at my office to learn whether she was pregnant. Not finding the pessary, which I felt sure she must have had replaced, as she had never reported that she was getting along without it, I questioned her about it. She then told me that, at the suggestion of her husband, she risked taking my advice, with the result of finding out that she was much better off. She had also been successful in regulating the bowels—in fact, she considered herself in perfect health. I found the uterus where it was two years before, decidedly retroflexed.

Still another case may be added to demonstrate my views: Eight years ago I got charge of a case of retroflexion complicated with uterine catarrh and a slight perineal rent. The patient also complained of nervousness, bearing down, rushes of blood to the head, and mental depression with a tendency to melancholia. She was wearing the third pessary (Hodge) within four months, and suffered considerable inconvenience from it. "You will become accustomed to it," she was told by her physician. The treatment I followed was: removal of the pessary; treatment of the catarrh by dilatation with tents and chloride of zinc applications; regulation of the bowels by means of proper diet; persistent soliciting of daily evacuations (she took daily injections for over a year); work, and cold baths. The result was very satisfactory. Through misfortune in her husband's business a great deal of housework fell upon her, but she bore up bravely. Only a week ago she told me that she enjoyed better health than ever. She works a

great deal, attending to her duties as wife and mother. Her bowels are kept in perfect order. She has not been examined for three years, but the womb no doubt remains retroflexed.

By following the principles outlined above, I have been constantly diminishing the number of cases where I really thought that a mechanical correction of the position of the uterus would be required in order to accomplish a perfect cure. There were cases of chronic metritis where a bulky, hard or soft uterus, filling out Douglas' cul-de-sac, was freely movable and more or less easily brought forward, either bimanually or with the aid of a sound. I have often seen cases of firm adhesions. Only the other day I examined a patient on account of a suspected miscarriage, and found a retroflexed uterus utterly immovable, the rectum running up to the left side of the fundus, and its passage in no way being interfered with. I have known that woman over ten years. She has never been sick a day, from which we see that, in her case at least, the retroflexed, adherent uterus had caused no symptoms whatever. In one case, however, I had determined to try to free an adherent, retroflexed uterus. It was a woman of 22, who, after her first confinement, complicated with fever, was kept in bed for four weeks. Three months after the confinement I found an entirely retroverted uterus, seemingly adherent to the rectum with its entire posterior surface. The uterus was so soft and flabby that I first thought it necessary to tone it up by the protracted use of hydrastis. At the same time I gave her my usual directions concerning her general health. She improved so much that she thought the raising of the uterus not necessary, and stayed away after two months' observation. I have heard since that she gave birth to her second child. I have now four cases of retroflexion of a subinvolted, large, movable uterus, which I think would be benefited if permanent support in the normal position were feasible; but since the object of this paper is rather to dwell upon the general principles of treatment, I will not discuss what means of redress I shall resort to.

One word about pessaries. B. Schultze, who is a great advocate of the mechanical method, has in his book brought forth the best argument to discredit their use. Everybody admits that the normal position of the womb is a slight ante-flexion, and, therefore, the correction of retroversion would mean to bring the fundus uteri forward and *keep* it there. It is obvious that the Hodge pessary, which is far oftener used than any other kind, is not constructed with a view to support the anteverted uterus, because it never pushes the cervix backward towards the sacral excavation, as it ought to—according to Schultze—in order to keep the fundus securely in an anteverted position. Assuming this view of Schultze to be correct—and I think it is—the improvement which patients feel, and which thousands of doctors who are advocates of the Hodge pessaries recognize, must be attributed to another cause than the pessary. The true explanation is auto-suggestion. The following case may be adduced as an illustration: A young lady of 19, coming back from Europe, called at my office to continue treatment of the womb which was begun four months before in Germany. She had been curetted and a Hodge pessary inserted. I found a remarkable short vagina, profuse uterine catarrh, free broad ligaments, a retroverted uterus of normal size, and a general rawness of the parts which I thought due to local treatment and possibly aggravated by masturbation. I removed the pessary and discontinued the local treatment. The improvement was remarkable. After two months I told the patient to return in a month. She, however, left the city and stayed away two months. When she returned she felt entirely well and expressed the hope that she would continue so after the ring should be removed. I was so

perplexed by this remark that I began to doubt whether I had really removed the pessary. Of course examination showed that it was not there, but I did not dare to tell the patient for fear she might get a relapse of her hysteria. She feels splendid now, and is still under the impression that she is wearing the pessary. In two months the time will be up when, according to our agreement, I shall "remove" it, or rather shall tell her that she has not worn it for four months. I also know of a case in the practice of my friend Dr. Dietrich where a woman never felt as well in her life as when she was wearing an imaginary pessary for six months.

It may be that my views are too radical, yet it is easy for any one who believes in the importance of the position of the uterus, and who also uses pessaries or some other mechanical device, to correct a displacement, to test in his own office the soundness of my statements. Let him change his treatment of such cases for a year, and he will find that he has not in any manner thereby injured his patients, but greatly improved his results.

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### Society Reports.

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#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DEC. 4, 1891.

The 258th regular meeting was called to order by the President, Dr. Robert Johnson.

*Dr. Thomas Opie* read a paper on THIRTY-TWO UNSELECTED ABDOMINAL SECTIONS. These cases were operated upon by Dr. Opie at the Baltimore City Hospital in the twelve months ending October 31, 1891. The conditions for which the operations were performed were as follows: Ovarian tumors, 6; chronic oövaritis, 7; fibroid tumors, 4; pyo-salpinx, 5; retroflexions with adhesions and dysmenorrhœa, 3; exploratory incisions, 3; extra-uterine pregnancy, 1; cyst of broad ligament, 1; cystic degeneration of ovary, 1. The number of deaths was four, as follows: Oöphorectomy for double pyo-salpinx, 1; shock for oövariectomy, 1; oöphorectomy for acute mania, 1; abdominal hysterectomy for fibro-cystic tumor, 1.

Stitch abscesses occurred nine times, most frequently in cases where the drain tube had been used. Early opening of the abdominal dressings favor their occurrence. When the dressings remained intact for seven days there seemed to be greatest immunity from the stitch abscess. Dr. Welch says that the staphylococcus epidermis albus is the most common cause of stitch abscesses in wounds treated aseptically and antiseptically.

Drainage was used in but three cases. In one case it retarded convalescence; in another it seemingly did no good and a small superficial abscess at the entrance of the tube followed its withdrawal; in the third case an abscess also occurred at the site of entrance. A plentiful supply of fine properly prepared elephant-ear sponges will do away with the necessity for flushing in most cases and remove the need for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac, in positions below the pedicle, in taking up blood or secretions, in staunching hæmorrhages, in separating adhesions, in protecting the intestines while closing the abdomen.

Drainage is doing more harm than good and ought to be abandoned by the ab-

dominal surgeon. The oft-repeated removal of dressings of the patulous drainage tube must of necessity be a very great danger; surely it favors decomposition and invites germs. After an anæsthetic, restlessness and jactitations are not wholly restrainable and it is easy to see how physical injury may accrue to the patient during the time from these smooth but not at all innocent glass tubes. When the laboratory physician says that bruised tissue is a paragon field for the cultivation of germs, let us heed the warning and cast aside the drainage tube.

Dr. Parkes says as to drainage: "Views and practices concerning drainage have materially changed even since the antiseptic era began. Our predecessors drained to permit the escape of pus, which they knew would form. Until lately we have drained in order to prevent its formation. We seem now to be on the eve of an era when we need to drain but little or not at all. We resort to drainage now only of necessity in septic or infected cases. In other cases we drain mostly from habit or from fear. Indeed, when we start afresh, as it were, without previous infection, the practice of drainage is a confession of fear or of weakness, both of which are alike unscientific and unfortunate. It even seems to me that in many cases where all other aseptic requirements have been met we do much more harm than good by the use of drains."

Dr. W. S. Thayer spoke of THE TREATMENT OF FIVE CASES OF MALARIAL FEVER AT THE JOHNS HOPKINS HOSPITAL WITH METHYLENE BLUE. Immediately after the appearance of the article in the *Berliner Klinische Wochenschrift* for Sept., 1891, in which Gulmann and Ehrlich described the successful treatment of two cases of malarial fever with methylene blue, this treatment was begun with the cases of malarial fever entering the hospital. So far only five cases have been treated.

One case of tertian ague yielded immediately to methylene blue, 0.1 five times a day. No rise of temperature after beginning of treatment. No organisms in the blood after the third day.

A severe case of quotidian ague had one chill 26 hours after the beginning of the treatment (methylene blue, 0.1 every four hours) and a lesser rise of temperature without chill on the two successive days. After this the temperature was normal. No plasmodia seen after ninth day.

In a case of chronic malaria with pigmented crescents and small intracellular hyaline bodies in the blood, no organisms were seen after the ninth day under methylene blue, 0.2 four times a day.

In two cases of severe chronic malarial remittent, the temperature fell to normal in a few days, but there were occasional returns of slight fever and the organisms—hyaline bodies and pigmented crescents—had not entirely disappeared in 41 and 23 days respectively. In the former case after eleven days treatment with quinine a moderate number of organisms was still present.

In all the cases the drug was given as a powder in capsules. Slight burning sensations with micturition were usually present after taking the drug and were relieved by small quantities ( $\frac{1}{2}$  of a teaspoonful) of powdered nutmeg several times a day. The urine, under treatment, was of a deep blue color. The fæces when passed were not colored, but on exposure to air turned rapidly blue. The sweat and saliva were not colored.

The number of cases yet treated is of course too small to give a sufficient basis for any definite opinion as to the relative value of this drug and quinine. The experience is sufficient to show that methylene blue has a definite curative influence on malarial fever and to warrant its further trial.

*Dr. I. E. Atkinson* said that the discouragement which one nearly always finds in treating malarial diseases with other remedies than the derivatives of cinchona bark is due to the extreme usefulness of cinchona bark itself, for it is so promptly antidotal in its effects in these disorders that we are apt to be discouraged and not persist in the treatment by other agents. The testimony given to us by *Dr. Thayer* seems to show that in methylene blue we have another agent in the treatment of these disorders. The effects of the use of quite dissimilar drugs in these diseases is remarkable. Of course, we all know the value of arsenic as an anti-malarial remedy, and we know that iodine possesses properties in this direction, inferior to quinine, but still pronounced. Some years ago, prompted by some papers published by a physician connected with the English Army in India, who claimed that iodine had properties equal to cinchona bark, *Drs. Atkinson and Hiram Woods* made some observations on the treatment of malarial intoxication with iodine.

The results of these investigations showed that while iodine has undoubted anti-malarial properties, yet in a large proportion of cases it will fail absolutely. There is a wide range of remedies that possess this anti-malarial property and which would be valuable if we did not have cinchona bark to use.

The investigation reported by *Dr. Thayer* is most interesting and important, and further progress will be awaited with interest.

*Dr. Harry Friedenwald* read a paper on CHOLESTEATOMA, OR PEARL TUMOR OF THE EAR. Cholesteatoma is a bright white growth of pearly lustre and smooth surface, made up of distinct layers placed concentrically over each other; has no blood vessels and when examined microscopically is seen to be made up of layers of large, flat, non-nucleated polyhedral cells, stratified in layers. These cells are in every respect similar to the cells of the outer layer of the epidermis. Between them are found cholesterine crystals. The growths occur in the middle ear and in the mastoid cells; here they lie in cavities, which they frequently enlarge to very great size. The cavities have a very smooth surface and are lined by a very fine membrane which consists of a layer of periosteum upon which lies a rete malpighii. This is the capsule which surrounds and produces the growth. These growths are often found in cases of chronic suppurative inflammation of the middle ear, with perforation or destruction of the drumhead and frequently with polypi. But these growths have also been found without any other or any previous disease of the middle ear and with a perfectly normal drumhead. It has likewise been found in other cranial bones and in the pia mater.

Three cases of cholesteatoma; one small one with a minute perforation in Shrapnell's membrane; a second, larger, in which the outer bony wall of the middle ear had been completely destroyed; and a third, very large, and occupying a great part of the mastoid cells, which had perforated both externally and internally into the cranial fossa, were described.

The various views regarding the origin of cholesteatoma were then discussed. *Virchow* regards it as a heteroplastic tumor, whether found in the pia mater or in the bones of the skull and analogous to epithelial carcinoma. Other observers find its origin, in accordance with this view, in the embryonic development of the labyrinth from an involution of the epiblast or in an involution of the epidermis in the first bronchial cleft, whose destiny it is to develop into the eustachian tube and middle ear. A view distinctly different from the above is that cholesteatoma is a desquamative process of the membrane lining the middle ear; that it is an inflammatory product which is retained in the spaces of the middle ear and by gradual accumulation forms a tumor. This is the theory of



von Troeltsch. The difficulty encountered here lies in explaining how a cavity normally lined by a mucous membrane can cast off cells of a dermoid form and, even more, can take on all the characteristics of epidermis with a well defined rete malpighii. Von Troeltsch believed that the products of inflammation by irritating and pressing upon the mucous membrane caused the desquamation. This view has many adherents, who believe that the same process converts the mucous membrane into epidermis; and recently it is claimed that analogous changes are found in simple ozæna, the ciliated mucous membrane of the nasal cavity being changed into epidermis. Another manner of explaining the changes of mucous membrane into epidermis has been advocated by Wendt, Habermann and Bezold. It is claimed that when large perforations exist, and especially where the drumhead becomes adherent at the edges of the perforation with the inner wall of the middle ear, that the epidermis of the drum-membrane "gains ascendancy over the mucous membrane and extends with much greater rapidity over the entire district." Bezold goes further and claims that a simple tubal catarrh is frequently a cause of retraction and perforation of Shrapnell's membrane, that the edges of the perforation adhere to the walls of the space within, that extension of the epidermis over the walls of these spaces will follow, the cavity be filled by desquamation and the nucleus of cholesteatoma formed. Thus Bezold explains the fact that the upper part of the middle ear is often the seat of cholesteatoma and that cholesteatomatous matter was found in all his cases of chronic suppuration with perforation of Shrapnell's membrane.

In conclusion: If we bear in mind that cases of cholesteatoma have been reported without any history of previous inflammation, while, on the other hand, it is certain that many owe their origin to inflammatory affections of the middle ear, we will hesitate to accept any one explanation as the only one. As is frequently the case in other matters, so here it is probable that the various theories do not conflict, but each serves as the true explanation for different cases; or, as Kuhn puts it: "Cholesteatoma of the temporal bone is either a true heteroplastic tumor, as Virchow believes it to be in all cases, or it may also develop, in perhaps many cases, in the course of chronic suppuration of the middle ear, from epidermis, which has grown into the tympanic space from the perforated drum or the external auditory canal, and which has slowly and continually kept shedding its horny layer and thus forming the stratified cholesteatomatous mass."

*Dr. Hiram Woods, Jr.*, said there was very little written about this subject in any of the books published in the English language. Of all the books to which he has access, Roosa is the only one in this country who makes mention of it under the name of Cholesteatoma. Another name which has been given to these tumors suggests a possible origin of them in some cases. They have been called Adipocericiform tumors. They usually occur in chronic suppuration of the ear and in that particular variety where drainage is exceedingly difficult, as in the perforation in Shrapnell's membrane. It is a well-known fact that where inflammatory products cannot be removed on account of difficulty of drainage, poor vascular supply, or other causes, these products gradually undergo fatty degeneration, and caseation may take place in them. Cholesterine is one of the characteristics of the process of caseation, according to Green, and it would seem that the ordinary degeneration of pent-up inflammatory products might account for at least a certain class of these cases. They cannot be all accounted for on any one theory.

*Dr. W. H. Welch* agreed with *Dr. Friedenwald* in believing that there are various causes. It is not an anomalous occurrence to have cylindrical epithelium transformed into flat epithelium as takes place in some of these cases in the ear. We have analogous changes in mucous membranes in other parts of the body. *Virchow* has described a condition of pachydermia laryngis in which the epithelium of the larynx becomes transformed into laminated flat epithelium. Another illustration is in prolapsus of the rectum in which cylindrical epithelium becomes transformed into epidermis. The same is true of the mucous membrane of the prolapsed uterus. *Virchow* has also described the transformation of ordinary epithelium into ciliated epithelium. There is sometimes found on the peritoneum ciliated epithelium where we should have ordinary epithelium. There is nothing unique or particularly unusual in the mere transformation of the epithelium of the tympanic membrane into epidermis. Other cases present too much of the character of destructive tumors to suppose this to be the only explanation. Many of these are doubtless real tumors, which probably rest upon an abnormality of embryonic development: epiblastic structures become displaced and grow where they ought not to be. One severe case of pearl tumor seen by *Dr. Welch* was reported by *Dr. Coring*.

*Dr. Friedenwald*, replying to *Dr. Woods*, said that processes of degeneration and disintegration of the products of inflammation are very common in all sorts of chronic inflammation of the middle ear, but the products of such disintegration are quite different from products found in the cases described. There we have broken down pus cells and disintegrated matter but no flattened epithelium.

*Dr. Welch* was asked by *Dr. Friedenwald* if in cases of prolapsed rectum the epithelium is changed into real epidermis with a rete malpighii formed and flat cells losing their nuclei as on the skin, and replied that he had examined several such cases and in them there is hardly a rete formed, but we have, from below upwards, the cells gradually becoming flat, the topmost layer composed of real horny cells as in the skin.

WM. T. WATSON, Secretary.

The following reply was sent to a doctor inquiring of a State official if he will be allowed to practise in Connecticut by registering his name and the college from which he was graduated:

“Sir—Anybody can practise medicine in Connecticut. You do not need to register; you do not need a medical diploma; you do not need to know the difference between opium and peppermint; you do not, indeed, need to know anything. You can simply come and live here and begin to practise. The laws of Connecticut will sustain you in collecting your fees for professional services, if you render any which you choose to call such. But if you undertake to carry me or my trunk to the depot for pay, you must get a license. If you peddle matches or peanuts, you must get a license. If you collect the swill from your neighbors to feed your pigs, you must get a license. If you want to empty your cesspool, you must get a license. But you can practise medicine in Connecticut *without a license.*”

This about describes the state of affairs in Maryland, but it is hoped that a new effort will be made by the physicians and the people of this State during the session of the present legislature to prevent persons, who don't know the therapeutic difference “between opium and peppermint,” from practising medicine.

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BALTIMORE, JANUARY 9, 1892.

**Editorial.****THE ERA OF THE PESSARY.**

All human achievements of value are associated with a certain amount of misfortune, and this is truer in no department of effort than in medicine. The place of each improvement in the province of therapeutics must be learned through "bitter experience." The profession is perhaps the less cautious and conservative in regard to the employment of new agents because the "other man" is the one who gets the "bitterness" and the physician comes off with only the "experience." This accounts for the tendency of medical men of a certain stamp to rush to wild extremes in the employment of greatly advertised remedies. The judicial mind is greatly needed in medicine. One of the most hopeful proofs that the excesses of past times in the department of therapeutics will not be repeated in the future, is the presence in high positions of professional honor of men who are not readily carried away by waves of enthusiasm and who are fearless in standing by their own observations in the face of the greatest opposition. Thus Virchow saved us from the excesses of Kochism, stemming at its full the tide of enthusiasm for tuberculin and going in the very face of hundreds of testimonials as to its remedial powers.

The triumphs of Gynæcological Surgery have been associated with great excesses on the part of those surgeons who were content to follow the paths which brought gain and reputation with little thought of the mental anguish which might follow too hasty consent to castration. Here men of experience and reflection, like Goodell, have done great service by their protests, and the newer operations for partial ablation of the partly-diseased ovary bids fair to remove the stigma which has attached itself to ovariectomy.

No remedial agent has had a more remarkable career than the pessary. Re-discovered after centuries of disuse, it came, in the hands of certain gynæcologists, to be one of the most important remedies known. It was found that

nearly every woman's womb got aslant sometimes, especially when the upper part of the vagina was pulled to one side by a speculum, and the gynæcologist spent most of his time in getting the organ into a position which better suited his own ideas. The varieties and nomenclature of pessaries were the *pons asinorum* of many a student even within the last decade. Now that is all changed, since professors have begun to teach that it doesn't make any difference how a womb slants, provided it is freely movable.

A very strong plea against the excessive employment of local medication in the milder uterine disorders is made by Dr. Banga in a preceding column of this issue. The conservative family physician will sympathize with Dr. Banga in his desire to do away with unnecessary manipulations in the cure of the catarrhal disorders which affect so many women. Especially in the case of unmarried women and girls in their teens does the moral sense of the practitioner revolt against frequent examinations and speculum introductions, and even the daily use of the hot water douche.

In certain severe cases these remedial applications are necessary, but certainly every effort towards cure by general and hygienic remedies is to be welcomed.

#### THE NEED OF TRAINING FOR ABDOMINAL SURGERY.

In the discussion of a paper on Extra-Uterine Pregnancy recently presented by Dr. Byford to the Gynæcological Society of Chicago (*Amer. Jour. of Obstet.*, November, 1891), Dr. Robinson gave the following timely note of warning:

I was very much pleased to hear this paper and much more pleased at its tone. About two years ago in New York I saw considerable tendency towards conservatism, but this is the first conservative paper I have heard in Chicago. I do not believe that every case that has a little tympanites should have the abdomen opened. I do not think that every ectopic pregnancy needs an operation—I agree with the paper in that; even though there is rupture in the early stage and some hæmorrhage, I think they will get better. I have had an opportunity of seeing this kind of thing throughout Europe, and I have noticed that a woman will get sick under a local practitioner's observation, and will be ill for some time, and finally the doctor will take her to some operator. In Europe specialists do all the operating, but in this country about every man who can get a scalpel in his hand operates. I have seen several of these operations in Europe, where the case had gone six or eight weeks; the blood clots would be found coagulated and would be taken out, and the operator would say at the time that the women would have done better without an operation. Some of them died and some recovered, but they showed me that the woman would have done better without an operation, for nearly everything was absorbed from the abdominal cavity.

While in Toledo for eighteen months, I watched abdominal sections over a radius of fifty miles, and I noted ten cases who died on the table or immediately

after operation. Of course a great many of these cases were desperate and might have died anyway, but in most of them the operators were inexperienced, some of them not having done more than one operation and some of them none.

I remember a young man who came to a prominent gynæcologist there and asked him how he would do a laparotomy. He asked him how he would drain a belly with a tube standing straight up. The doctor told him, and then, thinking that the young man, who was totally without experience, was going home to do a laparotomy, he said: "Doctor, don't do that operation; you do not understand how to do it." But the young man went home and the next day did a laparotomy on a woman, 26 years of age, who had some tubal disturbance, and she died in twenty-four hours. I know of a number of similar cases, and I hope this paper of Dr. Byford will get to the physicians who have the inclination to operate but not the skill.

The ability of men is a good deal alike. Men's heads are much like the heads in a wheat field—nearly all on the same level. The training makes the difference. The young man who seeks to be an oculist does not commence by operating on a cataract; he goes to an experienced oculist and learns what to do. The neurologist studies long before he will attempt to explore the cranium for an abscess. The dermatologist studies long and hard before he claims to know how to diagnose difficult cases. Obstetricians learn their business before they claim authority to do operations. In fact, in no important branch of surgery or medicine, except in abdominal surgery, do men expect success without hard experience. Yet in abdominal surgery many, totally inexperienced, rush blindly, with sanguine hopes that their operation in the peritoneal cavity will, by fate, be a success. A raw operator is ignorant of the great principles which are the legacy of past accumulations; the laws of abdominal surgery are moulded on the faults of our predecessors. It requires time to learn the signification of shock and trauma to viscera. It requires months of operative work to know how to be clean in an abdominal section, and much experience is required to know what to do after the peritoneum is opened. It is selfish inhumanity that stakes a patient's life, and risks the success of an abdominal section in a fresh operator's hands, just because he must have a *first case*. It is better to let a patient die naturally than to kill him by an operation. These young men should go to the masters to learn how to do these operations. They should do dissections to learn how to do these operations. They should prepare themselves before opening the abdomen, and if not prepared they should send for a man who is skilled. They should learn how to handle the intestines and the viscera by operations on the lower animals. In many of the laparotomies I have seen the patient die from shock because the operators were not skilled. They took too long. Forty minutes' exposure of the intestines will occasionally kill a dog. I say that those who do this kind of work should be as skilled as possible, so that the least harm may be done to the peritoneum, and the operation may be finished in the shortest possible time. Watching the master's dissection, opera-

tions in the lower animals, and study, will alone fit a man to do abdominal sections so that the operator's skill will defy the criticism of professional witnesses and the operation bear the inscrutable judgments of time.

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### Obituary.

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#### PROFESSOR FRANCIS DONALDSON.

At a meeting of the Society of the Medico-Chirurgical Faculty of Maryland, held on Saturday, the 19th of December, 1891, for the purpose of passing resolutions concerning the death of Prof. Francis Donaldson, of the University of Maryland, Dr. W. C. Van Bibber said in part:

All of us here to-day are thinking upon the same subject. All of us will bear decorous and mournful tribute to our loss, but something more subtle than what may be written, more sincere than words, the secret thoughts of every one, will be sorrow and unmixed regret for the loss which we have sustained.

Of few other physicians, or of few men, could this be said in the same fullness as we can say it of the one whom we now mourn. There are men and there are physicians of whose talents and gifts those who know them, and especially their brethren, may be proud; whose careers may be cherished for contributing to the honor of their profession, who may have endeared themselves by personal qualities, or rendered themselves conspicuous by high achievements amongst men, but such distinguished persons have generally created jealousies, disappointed hopes, or offended susceptibilities, and when they are removed from the busy scene of life some bitterness is mingled with the cup of sorrow and mourning. It is fair to say that this is not so in or out of this hall to-day, in the case of our brother, of whom we have met here to speak in affectionate remembrance. There must be some cause which has contributed to this remarkable result. The chief reason of it, no doubt, is the character of the man himself. Those who knew him best will recognize at once the chief ingredient in that character to be goodness. It was this above all other things which brought a fascination to his person and gave him an influence which all recognized

“Duty was the word that came most familiarly to his lips—index of the thought that was ever uppermost in his mind.” It was this that made him a power, it was this that made him so valuable wherever he was known. It was not long before men of all kinds, in and out of the profession, learned that this was no empty phrase with him, but was the expression of an inflexible principle. “The word duty sounds coldly, even harshly, in some ears; it is a guide, to follow which takes a man through rough roads to lodgings often of little ease,” but with him it meant all that which is dear in life implies. He wished to do what he considered his duty to every person, upon every subject and in all ways, and thus actuated by a high principle, his opinions and actions were received with respect and trusted as genuine.

Such a life might not appear at first glance to be one that would attract general attention, but within the limits of this society, where he was not only so well-known, but so much beloved, anything connected with him will be interesting. The entire details of his life would indeed bring up the whole history of medical things in this city for the last half century. This would be too long a subject to be entered upon now. But if the force and power which his example gave to those around him made his presence of value amongst us, there must

have been a beginning to the development of that goodness which has been recognized as his chief attribute. Therefore, what I shall say now will be principally connected with his early student life, because concerning this period there are now but few remaining who can testify concerning his marked ability and influence.

It was about the middle of September, 1842, when I first saw Dr. Donaldson. I was introduced to him in the office of the late Prof. Samuel Chew. Medical study, teaching and practice were then upon an entirely different basis from what they are here now. There were then but two medical schools and only three offices in which students were received. Dr. Donaldson had entered the office of Prof. Chew, where all eyes were turned upon him as a model student. Industrious, painstaking, progressive and enthusiastic in his profession, moral and religious as a man, polite, genial and urbane as a gentleman. These marked characteristics gave him the power of leader, and held him high and apart as an example, not only in the office but also in the entire class of the university. It is no less certain, than it is a curious study, to find how, in limited circles, as in an office or a class, the individual peculiarities of each one will declare themselves. It is not intended, however, to dwell upon this subject more fully, than to say that Dr. Donaldson's extraordinary sensitiveness and shrinking from prominence could not prevent his presence being felt whenever it was known that he was at his post of duty. After leaving the office of Prof. Chew, he pursued his studies in the Calvert Hospital, and here also he attained the reputation of being a model student. He likewise became a leader here in the study of his profession. He devoted his days to observation and his nights to writing. His industry was the common property from which his companions drew an unlimited income. Here it was that the leading authorities in medicine of that day were discussed with a longing for truth and a struggle for discrimination which is seldom found in the early portion of a student's life. From the initial principles of anatomy through all the branches of medical study to the refinements of therapeutics, were found subjects of never-ceasing thought and discussion.

Those were indeed considered happy who had chosen this pleasing path towards the portals of their profession, but thrice happy were those who could then appreciate their good fortune in having the bright example of an industrious companion and a model student before them. He stimulated the entire class who were borne onwards toward high aims in the future. It is nothing but fair that I should here lay before you the part which I believe to be strictly true concerning this period of Dr. Donaldson's early student life. His sacred fire of enthusiasm and his glow of industry and ardor were irresistible, and, indeed, contagious, and he was thus a help and leader to all those around him. The leading authorities who were then studied in this hospital were Andral, Chomel, Louis, Trousseau, Power, Sweat, Stewardson, Watson, and others; and the physicians were Prof. Wm. Power and Dr. Thomas H. Buckler. Happy days! Tireless trimming of the midnight lamp, mutual assistance, and a perpetual search for truth, were incited by that student whose loss we meet here to deplore as a matured man.

Prepared by habits of study, equipped with knowledge and retaining his enthusiasm and industry, Dr. Donaldson now visited Europe, and in the Charity Hospital of Paris followed those masters whom he had learned to admire and never ceased to reverence. His studies and labors in Europe were of the same character as those he had chosen here.

Upon his return to Baltimore his interest in his profession never flagged for

a moment. Soon he was chosen to teach what he had so well learned, and in 1866 was elected a professor in the university from which he had graduated.

My part in the portrayal of his active and useful life amongst us is now finished. It is needless for me to speak further of his career. What he accomplished is known to all of us, for since the time he left the more quiet walks of the university and has been in public life, there are others here who have been connected with him and can speak of him to-day. I have endeavored to portray his earlier labors, and to draw a picture of his university influence strictly within the borders of truth. I have done this because his modesty was as marked a characteristic with him as his energy, and he would have much preferred that no mention should have been made of his merits, if in speaking of them there should be the least word of exaggeration.

Gifted by nature with a strong and active mind and body, the most noticeable point in his career was the self-culture by which he made all his talents and endowments subservient to his professional usefulness. He had from early life trained himself upon a high standard of religious and moral excellence, and from these he never swerved. By the rules of honor and the deportment of a gentleman he could always be depended upon. His affections were strong and deep, and his friendships true and lasting. The twilight of his useful and brilliant career was short, and a kind and beneficent Providence, in whom he so implicitly trusted, seemed to grant what was known to be his wish, that he should retain his usefulness to the end of his life.

He died from a disease of his heart which it was his specialty to cure, and in the last moments of his conscious life he displayed the same trusting reliance upon the principles of religion which had been the charm of his boyhood, and the secret of his influence as a student.

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### Medical Progress.

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#### TREATMENT OF INSOMNIA WITH DRUGS.

In the *Canadian Practitioner*, December 1, 1891, Dr. M'Phedran deals with this important subject in an article from which this extract is drawn:

In the aged, and in states of exhaustion, no hypnotic is more useful than alcohol. With it may be given the cardiac tonics, especially digitalis, caffeine, strychnine, etc. Cases occur not rarely in which there is great desire to sleep while going about during the day, or while sitting in a chair; but on lying down on a sofa or in bed the sleepy feeling is at once dissipated. This condition is due to vaso-motor paresis, by which the blood, on account of the weakness and dilatation of the vessels, is allowed to drain from the brain in the erect posture, rendering it anæmic, hence the sleepiness. As soon as the recumbent position is assumed, the dilated cerebral vessels fill with blood, and sleepiness disappears in consequence. Bromides and general hypnotics do little good in such cases; the best hypnotic for them is digitalis, given sufficiently freely to cause vaso-motor contraction and a reduction of the blood supply to the brain. The general health and nutrition should also receive attention. Champagne at times succeeds admirably in such conditions. Ale succeeds in some when other forms of alcoholic stimulants fail. The continued necessity for such stimulation shows that the sufferer has little nerve vitality to draw upon; then there is the great danger of the alcoholic habit being formed.



Opium is, in many respects, without a peer as a hypnotic. It is indispensable in painful affections, and equally so in the insomnia of heart disease. In the latter the dose should be carefully regulated, as in too large doses opium depresses the heart, while in small ones it acts as a heart tonic. When alcoholics fail in the insomnia of the aged, opium may succeed.

Chloral hydrate is probably our most powerful hypnotic, possessing a narrow range of other therapeutic use. Its use need not be discussed, being too well known. The grave objections to its use are the danger of the chloral habit, its depressing effect on heart and respiration, and toxic effect on the kidneys. Its prolonged use leads also to mental enfeeblement, with intractable insomnia.

The bromides, by their sedative action and effect in rendering brain anæmic, are useful aids in inducing sleep, though they can scarcely be called hypnotics. They need to be given freely, and well diluted, during the day or evening. If long continued, they will defeat their own ends by their interference with cerebral nutrition.

In paraldehyde, I have had probably the most satisfactory hypnotic. In doses of one drachm or less it leaves no unpleasant effects, and usually is effective in producing sleep. It is useful in excitement, and its effect may be increased by the addition of a small amount of morphia. Its disagreeable taste and smell is its chief objection, and yet even that is of great use in some neurotic subjects.

Sulphonal, an excellent hypnotic in many, fails wholly in others. Its effect is not rarely prolonged into the next day, even then shown most markedly. It may even in moderate doses cause depression of the heart. It is dissolved with difficulty, and therefore slow in action. It is usually given, therefore, early after dinner, or dissolved in a good quantity of water, may be taken in divided doses later. So given, its effect has been found more certain.

Hyoscyamine I have not found of any benefit, even in doses of  $\frac{1}{25}$  gr. repeated; but my experience with it has been very limited.

Phenacetine is a very useful remedy in many cases of restlessness, especially if there is some fever. It may cause profuse diaphoresis, and thus be objectionable. It relieves muscular and other pains of slight degree.

My slight experience with urethan has not been satisfactory. It usually has failed, though it was satisfactory in some cases.

Turpentine is recommended in the insomnia of worry; it probably acts as a vascular stimulant.

#### BLOODLETTING FOR THE RELIEF OF CEREBRAL CONGESTION FOLLOWING INFLUENZA.

On July 13th I was called to see J. H—, a farmer, aged 64, who had always been a hale, hearty man. I found him complaining of great drowsiness, and slight pains, more or less general, all over the body, with well-marked occipital headache. The temperature was normal, and the urine on examination yielded negative results. I came to the conclusion that he was suffering from a mild attack of influenza, and ordered a saline aperient mixture. Before proceeding further I may here remark that I had just ceased attending his wife and servant for a rather severe attack of that malady. During the next three days his condition became worse, and the drowsiness having considerably increased, two blisters were applied to the temples and a large ice-bag to his head; the bowels not having acted, five grains of calomel were administered. On the following day his condition being unaltered, and the calomel not having acted, I

gave him a copious enema and effectually emptied the lower bowel. For the next four days he gradually got worse, his temperature was subnormal, the urine was passed involuntarily, respiration was of the well-marked Cheyne-Stokes character, and it was evident to all that unless some change took place he would speedily sink. Bearing in mind the somewhat distended state of the blood-vessels, I determined to perform venesection, and my brother, Dr. D. F. Whiteley, who now saw the case in consultation with me, at once agreed that bleeding offered the only means of saving his life. In order to see what would be the effect of gradual depletion, we applied ten leeches to his head; relief was at once apparent, respiration became normal, and on speaking to him he opened his eyes and appeared somewhat conscious. Unfortunately this condition was not of long duration, for in an hour respiration had once more assumed the Cheyne-Stokes type, and it was impossible to get any sign of recognition. Arguing from this that if more blood was withdrawn the improvement would be more lasting, I opened the vein in his left arm and bled to the amount of ten ounces; the effect of this was simply marvelous, for he at once became conscious and recognized a brother who had come a long distance to see him, and who, before the operation, was deeply grieved at not being able to obtain any response. For the following eight days recovery was uninterrupted, he regained consciousness, and was able to be moved from one bed to another. On my next visit, however, I was surprised to find him complaining of occipital headache and apparently very drowsy; this condition gradually increased, and he relapsed into a state of profound coma and appeared as bad or even worse than at first. With such a condition of things it seemed to me that a repetition of my former treatment was the only line to follow, so I applied several leeches to his temples; and from that moment improvement gradually became manifest; he made an excellent recovery, and is now, as he says, as well as ever he was in his life, and able to do a day's work.

*Remarks.*—The above case affords a brilliant illustration of the immediate effect of bleeding, for there is every reason to believe that without it he must very quickly have succumbed. I hesitated to bleed a second time, for his general condition rather contraindicated such a proceeding. However, it was done as a last resource, and happily proved successful. Years ago many people were bled regularly every spring in order to keep well, and very probably owing to its being done indiscriminately it fell into disfavor; but there can be no doubt that it is a very potent remedy, and, in properly selected cases, an ever-ready means of combating disease when drugs are absolutely useless.—Dr. Whiteley, *Lancet*, Dec. 12, 1891.

#### THE GROWTH OF FIBROIDS AFTER THE MENOPAUSE.

In an article before the Southern Surgical and Gynecological Association (*Atlanta Med. and Surg. Jour.*, January, 1892), Dr. Taber Johnson reported that he had within the past five years seen at least a dozen women with large growing and troublesome fibroid tumors of the uterus, who were over fifty years of age, some of them over sixty. These women had been assured by their physicians that if they could get along somehow until after the change of life their tumors would not only stop growing, but that they would lessen in size, and probably go away altogether; at least the troublesome and dangerous symptoms would disappear. They had been advised against any radical operation, and encouraged to believe that as they grew older they would get entirely well. In perhaps the majority of cases this might prove to be very good advice; but the point which the author wishes to make is, that as we are now better acquainted with the history and behavior of these tumors, this is no longer safe advice to give. We can-

not assure any woman that her tumor may not prove to be one of the exceptional cases, and that it may not grow more rapidly after the menopause than it did before, or that it may not present complications equally distressing and disastrous. When from forty to fifty per cent. of women subjected to supra-vaginal hysterectomy died from the effects of the operation, this was very safe and conservative counsel to follow. The possible dangers of the tumor were not equal to the probable dangers of the operation.

The author drew the following conclusions:

1. That the "rule" stated in the text-books, that uterine fibromata cease to grow after the menopause, has many more exceptions than is generally supposed.
2. That *when* they continue to grow after the menopause, they pursue a more disastrous course than before.
3. They more frequently become cystic, calcareous or have abscesses developed in them.
4. These conditions requiring operation according to well-known rules of surgery, the patients are in a less favorable condition for recovery than before the menopause.
5. If the above conclusions are admitted to be true, it must follow that they furnish additional indications for more frequent and earlier resort to the radical operation.

In the hands of the best operators in cases where a pedicle can be secured, the mortality of supra-vaginal hysterectomy is rapidly approaching that of ovariectomy.

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### Medical Items.

Lennox Wainwright, M. R. C. S., writes to the *British Medical Journal*: Hay fever has so many remedies that I almost hesitate to bring forward a simple remedy for relieving the nasal form of that ailment. The drug I have found most useful is menthol, and it acts best when placed in an ordinary smelling bottle mixed with carbonate of ammonia, and used as smelling salts. Patients say all irritability disappears, and in many cases they get no return of the symptoms.

The *Indiana Medical Journal* gives some interesting facts in the experience of the Medical College of Indiana. It seems that this college was organized in 1878. The individuals of the Faculty contributed of their services for the conduct of the college without any pecuniary reward. From time to time dividends were paid the members of the corporation from the accumulated funds of the college. In 1890 the treasurer had in his possession over \$3,000, and the property of the college was worth over \$7,000 more. All this \$10,000 had been derived from the conjoined labors of the Faculty. At this time two members of the Faculty left the college, and desired that they be given their portion of the accumulated capital of the college. This was refused, and a new corporation formed that retained the entire capital of the old college. The court decided that the two resigning members of the old Faculty were entitled to their portions of the capital of the old company, and appointed a receiver, authorizing him to bring suit for the recovery of said property.

The stomach of the average New Yorker must rebel against the consumption of water gathered at such expense from their newly acquired water-shed, when he reads that investigations by the Board of Health show that the east branch of the Croton, which furnishes the city with 50,000,000 gallons of water a day, is

foul with sewage from dwellings, barns, factories, outhouses and henhouses, flowing into it at more than one hundred specified points, and that the inhabitants in the towns and villages along the stream seemed to be absolutely without regard for the injury that they were doing the people of the city, and without respect for the laws for the protection of the public waterways.

The *International Journal of Surgery* announces that during the coming year its business department will be in charge of the gentlemen by whom it has hitherto been conducted, with the exception of Dr. Ferdinand King, whose connection with the journal company ceased on January 1st. The circulation of the journal, in addition to its steadily growing subscription list, will be maintained at figures largely in excess of any other surgical or medical journal, by the same energetic methods that have been employed in the past to add to its list of permanent readers. A monthly guarantee of circulation will be given advertisers when desired; an average of not less than 20,000 copies per month will be adhered to.

The Fourth Annual Session of the Southern Surgical and Gynæcological Association was held in the Rooms of the Young Men's Christian Association, in Richmond, Va., November 10th, 11th, and 12th, 1891. There was a very representative attendance of the surgeons and gynæcologists of the United States and Canada—especially Southerners. The President, Dr. L. S. McMurtry, of Louisville, Ky., presided with grace and dignity, being assisted at times by Vice-President Dr. J. McF. Gaston, of Atlanta. The Secretary, Dr. W. E. B. Davis, of Birmingham, Ala., to whose earnest interest and indefatigable labor the Association is more indebted than to any other member for its wonderful success, was also at his desk throughout the session. The evenings were given up to social entertainments. The membership of the Association is now limited to 150, and this maximum is now nearly reached. The Council is exercising much caution as to whom it elects to membership—thus making it a felt honor to be a member. The initiation fee or annual dues is \$10. The papers read and discussions had on them during this session were valuable and elicited the intensest interest.

The Johns Hopkins Hospital announces the following lectures (free to all resident medical graduates in the city on registration at the office of the Hospital) for January, February and March, 1892: Dr. H. M. Thomas, "Paralysis," Mondays, January, 3.45 P. M., February and March, 4.30 P. M. Dr. J. S. Billings, "History of Medicine," Mondays, January, 4.45 P. M. Dr. Wm. S. Osler, "Diseases of the Liver," "Polio-Myelitis in Children," "Treatment of Bright's Disease," "Digitalis," Tuesdays, January, February, March, 3.30 P. M. Dr. W. D. Booker, "Summer Diarrhœas of Children," Tuesdays, January and February, 4.30 P. M. Dr. W. S. Halsted, "Tuberculosis of Bones and Joints," "Tumors of the Neck," Wednesdays, January, February, March, 3 P. M. Dr. H. A. Kelly, "Pelvic Abscess," "Cancer of Uterus," "Retroflexion of Uterus," "Extra-Uterine Pregnancy," "Resuscitation of New-Born," "Contraction Ring," "Forceps," "Axis Traction," Wednesdays, January, February, March, 4.30 P. M. Dr. R. B. Morison, "Clinical Cases of Skin Disease," January, February, March, 2.30 P. M., Thursdays. Dr. Theobald, "Common Eye Diseases," January, February, March, Thursdays, 3.30 P. M. Dr. W. T. Councilman, "Intestinal Lesions of Typhoid Fever, Tuberculosis, Dysentery, etc.," Thursdays, January, February, March, 4.30 P. M. Dr. G. H. F. Nuttall, "Immunity," "Disinfection," Fridays, January, February, March, 3 P. M. Dr. W. H. Welch, "Infectious Diseases," Fridays, January, February, March, 4.30 P. M.

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## CONTENTS

### ORIGINAL ARTICLES.

- Report of a Probable Case of Fracture of the Sixth or Seventh Cervical Vertebra. By F. C. Bressler, M. D., Baltimore. . . . . 243
- Some Mooted Points Concerning the Vomiting of Pregnancy. By T. Ridgway Barker, M. D., Philadelphia. . . . . 245
- Case of Inversion of a Non-Puerperal Uterus. By John B. Roberts, M. D., Philadelphia. . . . . 248

### SOCIETY REPORTS.

- Medical and Surgical Society of Baltimore. Stated Meeting held Thursday, Nov. 12th, 1891. Twin Pregnancy with Placenta Prævia Centralis. Discussion. Cephalic Version. Discussion. A Case of Probable Fracture of the Sixth or Seventh Cervical Vertebra. Complete Recovery of Case of Purpura Hæmorrhagica Rheumatica. . . . . 250

### EDITORIAL.

- The Protests Against Vaccination. . . . . 252
- Therapeutic Notes from Practice. . . . . 253
- Mark Twain in a New Role. . . . . 255

### REVIEWS, BOOKS AND PAMPHLETS.

- . . . . . 255

### MEDICAL PROGRESS.

- Renovation of the Slums.—Influenza in England. —To Operate on the Ovary without Destroying the Procreative Function.—Third Dentition.—Genital Chancres in Women.—Cheyne-Stokes Respiration.—Electricity in the Treatment of Uterine Fibroids.—Dangers of Analgesin. . . . . 257

### MEDICAL ITEMS.

- . . . . . 263

## Original Articles.

### REPORT OF A PROBABLE CASE OF FRACTURE OF THE SIXTH OR SEVENTH CERVICAL VERTEBRA.†

BY FRANK C. BRESSLER, M. D., BALTIMORE.

On Tuesday evening, Oct. 22, about ten o'clock, Mr. R., aged 65, fell down about two steps while coming down stairs. While falling he struck his face against a sharp corner. He was placed on a settee and I was sent for. I saw him two hours later; found that he had bled very profusely from his nose and had spat considerable blood, probably that which ran into the pharynx from the posterior nares. Found that his nose was severely fractured, but presented no other evidence of cranial injuries. Mind clear, eyes not suffused; complains of a rigid or stiff neck, which becomes painful if head is moved. Nothing special could be observed along spinal column, except some pain close to junction of cervical and dorsal vertebra. Complains of marked pain in both shoulders, also has, every few seconds, painful shocks running down both arms, which he pronounced as spasms or cramps, asking those around him to pull his arms when these cramps occurred. Says he can't move his arms and legs since they are stiff; while lying down is not able to rise in a sitting posture unless assisted, and when assisted complains of severe pains while being moved. Has marked wrist drop. When limbs are touched says he cannot feel it—anæsthetic. The next day found that his paralysis was unchanged; his painful paroxysms in arms still present; passes his urine in bed; bowels not opened; mind clear; no

†Read at the 731st meeting of the Medical and Surgical Society of Baltimore, Nov. 12th, 1891.

complaint of pain along spinal column; seems cross and irritable; refuses to eat; unable to sleep, and restless. In this condition he remained for the following four days without any marked change. On the sixth day his condition was as follows: anæsthesia complete from the base of the spine of scapula downwards; failed to recognize heat, cold, pressure (light and deep); in short, anæsthesia absolute; electricity not tried; bed soiled from constant passage of urine; on both buttocks are two immense bed-sores; on both heels where they pressed on the bed, two immense water blisters; on the anterior surface of left arm a small strip was found that seems slightly sensitive to the prick of a pin; sometime he recognized it, again he failed; coughs considerable, owing to a sub-acute bronchitis, but is unable to expectorate; temperature 100; wrist drops unchanged, but is able to move arms slightly, owing to the contraction of shoulder muscles, which moved, indirectly, the arms, the latter moving as if they were one solid piece, and when he wishes to move arms, does so by a sudden jerk; spinal column rigid, which still is painful on motion; chin rests on sternum; if head is forced back cries out, and moves the whole spinal column in order to move head backward; not able to rest on his back, but rests better on his side; still unable to move himself; no change in contour of spinal column can be seen or felt, but when in the proximity of the sixth and seventh cervical and first dorsal vertebrae, complains of fixed pains when pressed upon; patellar reflex gone; plantar cremasteric and abdominal reflexes gone also. When upper half of pectoralis major is percussed reflex fibrillary contraction is fairly rapid, while lower half responded sluggishly. On percussing muscles on back down to angle of scapula contractions were gotten, while below angle, no response is observed. Next day, seventh, no marked change is observed except patient is getting weaker; pulse 92, temperature 101.

Eighth, cough became more annoying; restless; passed his fæces in bed; urine bloody; paraplegia, both motor and sensory, present to the same degree as at first. Muscles remained in a well nourished condition; heart normal as far as could be made out; blood vessels atheromatous; mind clear. His condition became gradually worse, and died on the morning of the tenth day, from exhaustion. The diagnosis of this case is problematical, since no post-mortem could be gotten. Nevertheless, I think this case has several features worthy of your attention. One is the slightness of the fall which led to such severe injury, with fatal result. It demonstrates to us the dangers that attend upon trifling falls of the aged.

Another interesting point is, what was the pathological condition that induced all these symptoms? From the history it is beyond cavil that the injury could not have been anywhere else but around the sixth cervical to first dorsal vertebrae.

The question again was, is it a fracture of one of these three vertebrae or an intra-medullary hæmorrhage?

Owing to the spasmodic jerks and rigidity, I think intra-medullary hæmorrhage can be excluded.

Again, was it extra-meningeal? It seems to me the symptoms partly fit but not altogether, since trophic changes, rectal and vesical symptoms, paralysis and anæsthesia are not so well marked as a rule as in this case. It then leaves but one condition that it likely was and that was a probable fracture of the vertebrae with resulting hæmorrhage, followed by a rapid transverse (compression) myelitis. I think fractures are the more common and frequently have the same train of symptoms as presented in this case. Unfortunately the family was ignorant and the case hampered considerably by their refusal to submit to any line of treatment.

## SOME MOOTED POINTS CONCERNING THE VOMITING OF PREGNANCY.

BY T. RIDGWAY BARKER, M. D.,

Demonstrator of Obstetrics in the Medico-Chirurgical College, Philadelphia; Out-door Obstetrician to the Penn Dispensary.

In discussing the etiology, symptomatology, and prognosis of the digestive disturbance associated with gestation known as morning sickness, or the vomiting of pregnancy, it becomes necessary at the very outset of a comprehensive study of the subject to exclude those forms of gastric troubles which, while often accompanying this purely physiological process, are nevertheless not dependent upon it for their existence, but upon some preëxisting morbid condition which is simply aggravated by the changes incident to gestation.

To a failure to appreciate and differentiate between these forms of gastric disturbance is largely due the confusion and misconception which is so general, hence the existence of such a multitude of views as to the cause and gravity of the vomiting of pregnancy.

It becomes necessary, therefore, that we state clearly that when we speak of morning sickness we do not include the so-called vomiting *in* pregnancy, but confine our remarks solely to the vomiting *of* pregnancy. Without further explanatory remarks, let us proceed to a consideration of the subject from a scientific standpoint, ever mindful, however, how easy it is to advance a theory and how difficult to find evidence to support it. That the occurrence of vomiting without apparent cause in females who have exposed themselves to the risk of conception is a sign of much importance is generally admitted, since it so quickly follows cessation of menstruation and, therefore, further tends to confirm the presumptive evidence of pregnancy. With reference to its etiology, one finds as many views as there are stars in the sky, each differing from the other in magnitude and brilliancy even as these distant orbs of light. Let us then turn away from such a merry-go-round of medical opinion and seek to discover the truth in the realms of anatomy and physiology rather than in the domain of idle speculation.

Coincident with conception, we find a general rise in the intra-pelvic blood pressure, resulting in increased activity on the part of all the viscera therein contained which are concerned in the process of reproduction. Cells heretofore carrying on a passive existence now spring into a high state of activity. Likewise there occurs hyperplasia and hypertrophy of tissue, which is especially rapid in the uterine muscular elements. Nerves, which in the unimpregnated condition possess but a low grade of sensibility, now become highly sensitive and transmit readily to their respective centres slight disturbances which under other circumstances would fail to throw them into a state of inactivity. What relation, one may very properly ask, exists between the vomiting of pregnancy and this exaltation of the nervous system? A causal one, most assuredly.

Can one fail to realize that this is a symptom of pregnancy due to the change in the nervous equilibrium induced by the process of gestation? Surely not. Rather are the nausea and vomiting expressions of a reflex irritation having its origin at the end-organs of the uterine nerves which, as we have seen, are in a hyperæsthetic state. As the growing ovum demands, day by day, an increased space for its development, these end-organs are subjected to a varying degree of irritation which is transmitted to the centres and thence reflected out along the nerve-filaments distributed to the stomach. Why this affection is of

†Read before the Philadelphia County Medical Society, December 23rd, 1891.

more frequent occurrence and of greater severity in the first than in subsequent pregnancies one can readily understand by comparing the cavities of the primiparous and multiparous organs.

We find in the former that the uterine muscular walls are convex and nearly, if not quite, in apposition, hence the capacity of the organ in these females is relatively less. Not so the multiparous uterus, for its walls are concave and the capacity is further increased in length by one-half an inch, owing to incomplete involution on the part of Nature after the first pregnancy. Need we ask for more conclusive evidence than this to support our position? Is it not plain to be seen that resistance in the primiparous organ will be greater and the nervous disturbance more pronounced than where the cavity is larger, thus allowing the ovum to undergo its development without interference? Further, the period when nausea and vomiting are most apt to occur is in the second month, at a time when the growth of the uterus is principally lateral and the villi of the chorion are thrusting themselves into the serotine or placental decidua. As to the character of its onset, it is usually gradual and disappears in a similar manner as the uterus rises out of the true pelvic cavity, thus having quite ceased by the end of the fourth month.

Concerning the symptomatology of this affection, it has not a few well-defined characteristics. The primary nausea and oppression experienced over the epigastrium soon gives place to vomiting, not, however, preceded or accompanied by any degree of nervous depression, as is the case with emesis under all other circumstances. The food, if any is present in the stomach, is expelled, not violently nor with any amount of retching, but almost as if it were regurgitated. Should the stomach be empty, then simply a little clear, normal gastric mucus is raised, which, as it usually occurs early in the morning, has given rise to the popular appellation of morning sickness. Further, if the matter vomited be food, it will not be found on examination to be sour or to have undergone decomposition, but in a more or less perfectly digested state, depending upon the length of time since its ingestion. As to the subsequent amount of nervous depression, in most instances it is practically *nil*, even when the vomiting is frequent and of long duration. This fact is very noticeable in some cases; the pregnant female may have just finished a hearty meal—for impairment of the appetite is rather the exception than the rule—when almost immediately afterward she will be obliged to evacuate the stomach, only to turn to the piano and find consolation for her lost breakfast. Rarely does one meet with a case of vomiting of pregnancy where the female's health has materially suffered, and this is what one would reasonably expect from a study of the symptomatology of the affection.

That this digestive disturbance is a purely sympathetic one is proven by the fact that by a strong effort of the will the female can not infrequently ward off an attack.

Should she, for instance, have accepted an invitation out to dine during this period of gestation, she can control the nervous irritability by a firm determination not to betray her condition to the assembled guests. It has been repeatedly asked, How can a woman suffer from morning sickness at one period of gestation and not at another? In other words, How is it that the attacks vary in severity in different pregnancies? Moreover, Why is it that one pregnant woman has morning sickness and another does not? Can this be explained on the hypothesis of reflex nervous irritability? Most assuredly!

The variability in the duration and severity of the affection is due to two fac-



tors: Greater or less irritation, and greater or less irritability. The question may here be asked, Is vomiting of pregnancy a physiological or a pathological process?

It has been stated that among women of a strong, robust type, vomiting of pregnancy is exceptional rather than the rule, as is the case in Europe and America. But this fact has no direct bearing on the case; it goes without saying that the stronger and less sensitive the nervous system the less general and severe will be the sympathetic disturbance. One certainly is not warranted in stating that the vomiting of pregnancy is a pathological process, for it is due to a purely physiological cause. There exists no morbid alteration in structure or function of the nerves. The irritability is not pathological but physiological, depending upon the degree of sensibility of the nervous apparatus. Yet it has been claimed by some investigators that this very exaltation is evidence of some pathological lesion. Surely not. It were, it seems to me, as reasonable to declare a person's brain diseased because he is irritated by Wagner's music, in which he finds no harmony, as to declare that the sympathetic disturbance excited by pregnancy is due to some morbid process.

Again, if we select two galvanometers, one registering the weakest electric current, the other equally well constructed but less sensitive, we cannot say that the former is any more perfect than the latter; they differ simply in the degree of their sensibility. Difference in sensibility within certain prescribed limits is a physiological, not a pathological, fact. While vomiting, as Austin Flint points out, is not, strictly speaking, a physiological process, yet under these circumstances it is far from pathological; rather let us say it is the pathological expression of a physiological process. The vomiting of pregnancy, unless complicated by some morbid process, never gives rise to alarming symptoms or threatens life. If prolonged beyond the period of quickening, its continuance may be accepted as positive evidence of some complication which a decided alteration in the character of the vomited matter will usually indicate.

Cases of pernicious vomiting call for diligent search for organic lesions in the nervous system or structural changes in some of the generative or associated organs. That the vomiting of pregnancy occurs in healthy, strong women almost as frequently as in their less robust sisters, though in a milder form and of shorter duration, only confirms the view as to its physiological nature. The view advanced that the difficulties attending parturition are proportionate to the severity and length of the morning sickness, one is scarcely prepared to accept. The gravity of the digestive disturbance is to be estimated by the amount of nervous irritability, while the difficulties of parturition may be classified under two heads: maternal and foetal. The former including uterine inertia, pelvic deformity, and rigidity of the soft parts; the latter, abnormal size of the foetus and malpositions of the foetus. Surely no such conclusions are justified, for the reports from the large lying-in hospitals of both Europe and America unmistakably prove no such relation exists. Females who have suffered great annoyance from morning sickness have frequently as easy and sometimes more rapid labors than those who have almost wholly escaped this unpleasant early indication of pregnancy. Therefore, in conclusion, it would appear from a study of this affection: First. That the vomiting of pregnancy is due to a reflex irritation produced by the developing ovum acting upon an exalted nervous system. Second. That it is not an affection of great gravity and need occasion no anxiety or alarm. Third. That active treatment is rarely demanded, as it is only a disturbance of a few weeks at the most. Fourth. That the severity of the gastric trouble is no

indication of the character of the subsequent labor. Fifth. That where the affection persists beyond the period of quickening, it is due to pathological causes which can be discovered and treated accordingly.

### CASE OF INVERSION OF A NON-PUERPERAL UTERUS.†

BY JOHN B. ROBERTS, M. D.,

Professor of Surgery in the Woman's Medical College of Pennsylvania.

This case seems to me of interest because of the comparative rarity of the condition. I give it simply as a contribution for clinical discussion.

Mrs. H., aged forty-three, in November, 1890, complained of having had bearing-down pain for some months, and a slight vaginal discharge, which had recently become offensive. Menstruation had been regular, and there was no great loss of blood at her usual periods. The woman had been married eight years; had had one miscarriage, but no children.

Vaginal examination revealed a reddish mass protruding from the uterus through a well-dilated os. As this was evidently a submucous fibroid tumor, a drachm of fluid extract of ergot was ordered to be taken three times a day, and douches of corrosive sublimate (1: 4000) to be used twice daily. A little later the vaginal douche was changed to carbolic acid solution.

About ten days after I first saw her the patient was etherized, and a sloughing, friable mass removed with the fingers and forceps, aided by a curette. The mass was about the size of a small orange. The patient recovered promptly and was discharged from treatment in about two weeks' time.

Three weeks later I was sent for to see the same woman, who was then very emaciated, exceedingly weak, and suffering intense pain in the abdomen, with the knees flexed upon the pelvis, and with an exceedingly fetid, profuse, and sanguinolent discharge from the vagina.

Pressing my hand upon the abdomen I found the bladder greatly distended with urine, and upon investigation I discovered that she had not passed any water for several days. Catheterization relieved this condition, and examination by the vagina showed the existence of another sloughing fibroid tumor. This was readily removed with the forceps and fingers. The patient recovered promptly, though she was still weak when last seen.

About three months later she came to my office exceeding pallid, with the statement that for some time she had been suffering from most profuse uterine hæmorrhages. Examination revealed protruding from the vulva a mass about the size of a small apple. Constant loss of blood was taking place, and the patient was so anæmic that she nearly fainted in my office, and had to be sent in a carriage to the Polyclinic Hospital. The vagina was packed, and the patient given full doses of quinine and whiskey. This was in March, 1891. After having been kept in bed for several days she was etherized, and a full examination of the uterine condition made. I found what I had previously suspected—a small growth attached to the fundus of the uterus, which had caused inversion of that organ. The mass occupying the vaginal outlet and the vagina was, therefore, the uterus, which had been turned inside-out, with the attached polypoid, fibroid tumor. I readily tore loose from the mucous membrane of the inverted uterus what was found to be two small fibroid tumors, one about the size of a

†Read before the Philadelphia County Medical Society, December 23, 1891.

black walnut, and the other rather smaller. They are shown on the plate containing the specimens, but are now shrunken from long immersion in alcohol.

An effort was then made to replace the inverted uterus by continuous pressure made with the finger introduced into the vagina. This was continued for a long time, but proved ineffectual. I considered at the time the propriety of removing the inverted uterus by performing partial or complete vaginal hysterectomy. It seemed to me, however, that it would be wise to make a further attempt at replacement before adopting radical measures. The patient was accordingly kept in bed nearly two weeks in order to build up her general health by stimulants and tonics, before making further attempts at invaginating the inverted uterine walls.

She was then again etherized, and a prolonged effort was made at replacement by means of the fingers and Aveling's repositer. The manipulation was kept up for an hour and a half, but was absolutely useless, although the pressure was made in a very continuous manner. The patient became so weak that I feared she might die upon the table, and I therefore abstained from further manipulation, and again put her back to bed.

Two weeks later another effort was made to overcome the inversion of the womb. I was assisted on this occasion by Drs. Baldy, Baer, and Anna M. Fullerton, whose counsel and aid I felt that I greatly needed. The abdomen was opened by a median incision, when the coils of the intestine occupying the pelvis were seen united by recent lymph, evidently due to the traumatism of the previous manipulations. An endeavor was made to correct the condition of the uterus by means of strong forceps introduced through the abdomen to dilate the uterine neck, while pressure from below was made with fingers in vagina. Although these manipulations were performed by such skillful operators as those I have mentioned, we were unable to make any marked impression upon the displaced organ. Unfortunately I had not provided myself with the most approved form of forceps. I then pushed through the fundus of the uterus a large needle carrying a strong piece of fishing line to which was attached at the vaginal end a button of soft metal. I hoped that traction on this cord through the abdominal wound would, by means of the button pressing upon mucous membrane of the uterus in the vagina, cause the uterus to assume its proper condition. While dilatation of the inverted fundus was made by means of the forceps, traction was made upon the string and pressure upward through the vagina. The muscular contraction of the uterine neck, however, prevented anything being gained by this manipulation, although the force applied was such as to finally cause the button to pull through the fundus of the uterus and to make its exit into the pelvis. After spending considerable time in these unsuccessful attempts, I finally did a partial vaginal hysterectomy, removing the inverted portion high up and stitching the edges of the uterine wall at the fundus together. This procedure was resorted to only after the patient had been under ether for three hours and was so overcome by shock that her condition was extreme. She did not react, her temperature not rising above 95° F., and she died within a few hours.

The abdominal wound was then opened, and a very small amount of blood found near the stump of the uterus. Evidences of non-septic traumatic peritonitis due to the previous manipulation were present, as has been stated in the account of the last operation.

In looking back upon this case, I cannot but feel a sense of regret that the more radical operation of vaginal hysterectomy was not done at the time that the patient was subjected to operation for removal of the tumors causing the inver-

sion. My desire to avoid an operation accompanied by shock and hæmorrhage at the time she had been so depressed by violent and repeated flooding, made me adopt what at the time seemed a less radical course. The extreme difficulty of dilating the uterine neck in cases of inversion was not appreciated by me until I found my attempts at replacement futile.

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### Society Reports.

#### MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, NOV. 12, 1891.

The 731st regular meeting of the Society was called to order by the president, Dr. David Streett.

Minutes of previous meeting read and approved. Dr. A. B. Arnold was unanimously elected to membership.

*Dr. Wilmer Brinton* read a paper entitled TWIN PREGNANCY WITH PLACENTA PRÆVIA CENTRALIS. DISCUSSION.

*Dr. Thomas A. Ashby:* Dr. Brinton is to be congratulated on delivering these twins alive and to have saved the mother, thus caring for the lives of three individuals at the same time. I have been fortunate in having had only a few cases of placenta prævia, in all of which the mothers were saved but the children have all perished. A woman whom I had attended once before, aborted; in this case the placenta was attached over the cervix. She has had two children born in a normal way since and another placenta prævia with an abortion at four months. Laceration of the cervix is the cause of more intra-pelvic disease than any other one cause I know of. In my abdominal work I find there is a direct connection with lacerations of the cervix. One lady, seven years ago, aborted at seven months, when she had a laceration of the cervix; she had a tender ovary and had catarrh of the uterus, for which she came under my care. She was delivered about ten weeks ago; it was a hurried labor. I found a large laceration arrested involution, and she was on the point of septic inflammation. She made a good recovery and I turned her over to her family physician. In these cases of cervical laceration we should not trust our patients to a nurse, we should wash out the uterus ourselves. In washing out the uterus I find it a good plan to pass the solution in on cotton wool on an applicator, and swabbing it around; this brings out the fragments better than the douche. I believe that 75 to 80 per cent. of pelvic inflammations in multipara are due to neglected lacerations of the cervix, allowing of septic absorption. Put in a bivalve speculum and wash out with an antiseptic solution. The gynæcologist will stop work if the general practitioner will use these measures.

*Dr. W. S. Gardner:* I congratulate Dr. Brinton on delivering both infants alive. In regard to phlegmasia alba dolens, I think it is a septic process; it, in all probability, is not a phlebitis, but most likely it is an inflammation of the connective tissue around the vessels and the clot in the vessels is a secondary process. A number of post-mortems in these cases have shown no clot in the vessels. Now, as to cleaning out of a uterus, there are several methods of doing this. 1st, there is the douche, that will remove the ordinary loose clots. Then there is the swab, that will remove some things that the douche will not, but not much; the most efficacious method of removing bits of placenta is by the use of the curette, and should be more generally practised than it is.

*Dr. Wm. H. Norris:* There is one point that forces itself on my attention and that is that young physicians are too prone to trust the nurse, presuming that their directions will be carried out. None but medical men or trained nurses can do these things right. A case occurred in my neighborhood, where the physician gave the nurse instructions to wash out the uterus twice daily. She washed out the vagina and in a short time a consultant was called in to see the case, when it came to light that the uterus had not been washed out; the physician did it himself after that; and this shows that the only safe plan in these cases is to do the work yourself.

*Dr. Brinton:* I agree with Dr. Norris that it is not safe to trust too much to the nurse in these cases, but the average doctor couldn't wash out the uterus properly; it requires some training to do this and unfortunately all doctors have not had the advantages of this training. For the same reason, I do not agree with Dr. Gardner in the use of the curette; curetting a uterus is attended with some danger and I think it should be done guardedly. The point I wish to bring out in my paper and which seems not to have been touched on in the discussion, is *prompt* treatment in these cases. I prefer podalic version, but forceps can be used in some of them, when we may do as well; but in the vast majority of cases it is better to turn and deliver. Three months ago, in a case of a mulatto at term, with Dr. Robinson, we did a podalic version and did it *promptly*. Both mother and child were saved and the child is living to-day; this is the only case I know of where the child has survived so long. The point I wish to emphasize is that these cases should be treated *promptly*.

*Dr. W. S. Gardner* read a paper entitled CEPHALIC VERSION. DISCUSSION.

*Dr. F. C. Bressler:* I remember a case in which I should have done a cephalic version, but in my haste I did podalic version. She was a primipara, bleeding from a placenta prævia. I found I could cause considerable mobility of the uterus by placing my hand on the abdomen. I ruptured the membranes and introduced my hand for a leg and did podalic version. The child was lost, whereas, had I done cephalic version as I could have done, in all probability the child would have been saved. In another case I attempted to do cephalic version and failed. It was a midwife case, a multipara at eight months. She had a large vagina, so that I could introduce the whole hand. I put her in the knee-chest position, but with all my manipulation I could not get the head in position, so had to do podalic version. In this case the child was saved. Many doctors do not seem to know there is such a thing as cephalic version. If it were more generally practised there is no doubt that many would be saved that otherwise perish.

*Dr. F. C. Bressler* reported A CASE OF PROBABLE FRACTURE OF THE SIXTH OR SEVENTH CERVICAL VERTEBRA. (See page 243).

*Dr. Wilmer Brinton* reported the COMPLETE RECOVERY OF THE CASE OF PURPURA HÆMORRHAGICA RHEUMATICA, that he exhibited to the Society on the 23d of April, 1891. (See page 99, Vol. XXV). After nine months of treatment he has returned to his work as clerk. The treatment at first, as I stated when I exhibited him here, was the administration of gallic acid, tannic acid, etc., all of which seemed to do him no good. Then I put him on large doses of salicylic acid, large doses of elix. of iron, quinine and strychnia; and, I am glad to say, for the encouragement of some of you, who may look upon some of your cases as hopeless, as I did on this one, that after prolonged and persistent treatment he has returned to his work.

**THE MARYLAND MEDICAL JOURNAL.**

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A. K. BOND, M. D., Editor.

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BALTIMORE, JANUARY 16, 1892.

**Editorial.****THE PROTESTS AGAINST VACCINATION.**

A friend has handed to us a little tract against compulsory vaccination laws. There has been ever since the introduction of vaccination for the prevention of small-pox, a steady opposition to its employment. At first the opposition was grounded on the claim that the introduction of bovine virus was liable to beget in the patient an animal nature. The caricatures of that day represent the most remarkable phenomena—horns sprouting from the forehead, brutalization of the features, etc.

The battle next shifted to the ground of the communication of loathsome diseases through the medium of the virus, especially when it was obtained from a pustule on some human patient. This contention may now be considered settled by the general use of virus obtained from selected healthy heifers.

An effort was made to prove that vaccination did not protect against small-pox, but this assertion has again and again been disproven by experience.

The plea is now put forth that small-pox has, during the long interval which has elapsed since its time of universal prevalence in civilized communities, lost its intense virulence and that it would not now, if vaccination were completely abolished, spread through the community as in past times; hygienic regulations and isolation sufficing to keep it within reasonable limits. This plea is based on the well-known fact that other contagious, self-limited diseases of world-wide prevalence have had their rise and fall according to laws unknown to science—the disease increasing rapidly at its first appearance in a community, and gradually becoming less and less intense as the generations and centuries rolled by. This seems to be due either to a degeneration, in respect to intensity, of the disease poison, or else to a resistance of the human body to its assaults, acquired by generations of victorious struggle against it.

That small-pox is a disease which has lost its virility is disproven by its rapid

spread and its large death-rate in communities where it finds large numbers of unvaccinated persons. That isolation of the sick cannot be depended upon as our sole preventive of the disease is evident to anyone who considers the inefficiency of the sanitary laws (except in certain great cities and in populous and unusually intelligent communities) as regards the prompt and effectual isolation of those suspected to suffer from small-pox.

In making vaccination compulsory, and in requiring vaccination before admission to the public schools, it is the duty of the local authorities to provide vaccine matter which does not cause needless inflammation and suffering, and to avoid the vaccination of persons, young or old, at times when they may happen to suffer from diseases, local or general, which predispose to ulceration and excessive inflammation.

If this be done, there can be no reasonable objection to compulsory vaccination of the whole community.

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#### THERAPEUTIC NOTES FROM PRACTICE.

I. We have recently obtained great benefit in the obstinate pleurodynia, which marks the later stages of certain cases of influenza, from the use of compound ipecac powder (known commonly as Dover's powder) given in five grain doses every four hours in capsule. It has caused no disturbance of the digestion and none of the other disorders of function which so often follow the administration of other opiates. Moreover, sleep is secured, a thing greatly to be desired. The exact nature of this pain over the lungs is not evident. One would suppose that a localized pleurisy was the cause of the suffering, were it not that the symptoms suddenly shift from one spot to another and that effusion into the pleural cavity does not occur, as is shown by the normal resonance on percussion.

II. A lady affected with influenza, whose headache and pains in the upper portion of the trunk had yielded to phenacetin or antipyrin, suffered still with an intolerable aching of the lower limbs, especially in the region of the knees, not relieved by hot, moist applications. The employment of the constant current, in the strength of about 40 cells of the chloride of silver battery, secured speedy and permanent relief from pain, and the patient sank into a restful slumber, waking to rapid convalescence. The current was passed, first on each side from the hip to the ankle, and then from one ankle to the other.

III. A tumor of the size of a pea, which appeared and grew to this size in two weeks, on the lower lip of a colored woman, and which bled furiously at times from its broad base and from an abraded spot on its smooth, rounded, distal surface, was transfixed in several directions at its base by the electric needle. No bleeding of moment occurred. A ligature of fine silk was now tied about its base, and at a visit four days later, the tumor had fallen off, leaving a small, quickly-healing sore. Operations with the electric needle are remarkable for the absence of pain and of hæmorrhage even from very vascular

tumors, especially if the current be changed before the needle is withdrawn, making the needle a positive and styptic electrode.

IV. A dressmaker had suffered for a week or more from stiff neck, which compelled her to carry her head "on one side," and, in addition to its painfulness, greatly interfered with her sewing. The constant current was passed by sponge electrodes through the affected parts for almost fifteen minutes. The patient experienced great relief and could move the head (which had been straightened by gentle force during the passage of the current) much more freely than before. She returned in the evening, stating that she did not think the further use of electricity necessary, as she had worked in comfort all day. No other remedy than the single application of the current was used in this case.

V. A female patient about 35 years of age was suddenly, after a slight cold and aching of a few hours' duration, seized with convulsions, apparently epileptic. The convulsions continued from 6 P. M. to 3 A. M. (nine hours) in spite of remedies, the intervals between them being at first a few minutes, and afterwards about a half hour. There was unconsciousness during the whole period, with inability to swallow. The convulsions began with fixation of the eyes, traction of the head to one side followed, then strong flexion of the arms with turning in of the thumbs, stiffening of the straightened limbs and biting of the tongue. The pulse was quick and feeble between the paroxysms. Hot bathing of the feet and legs, poultices to the abdomen, inhalations of large quantities of nitrite of amyl, subcutaneous injections of brandy, enemata of bromide of potassium and inhalation of small quantities of chloroform vapor, all in turn failed to prevent recurrence of the paroxysms. The bowels responded only sluggishly to drop doses of croton oil, in castor oil, on the tongue, and to copious injections of water into the bowels. Finally, observing that the patient groaned somewhat between the paroxysms, and supposing that the convulsions might perhaps be immediately caused by a severe attack of the influenza pains (possibly in the form of headache or backache) the writer injected morphia,  $\frac{1}{2}$  grain, hypodermically. No more convulsions occurred.

The patient was better next day, and then passed into a restless state resembling mild delirium tremens, which lasted several days; convalescence being established in about a week from the first convulsion. The patient was a drinking woman, had had one epileptic attack a year or more before, and was suffering from sudden check of the menses at the time of the convulsions just described. In another case now under the writer's charge, *grand mal* was certainly precipitated by an attack of influenza with severe headache, the whole trouble disappearing after the use of a hypodermic injection of morphia,  $\frac{1}{2}$  grain, followed by a dose of Epsom salts. A state resembling delirium tremens has been occasionally observed in the past three years, associated with and caused by the influenza poison.

VI. A neat dressing to lay upon a deep wound after sutures have been inserted and tied, is a single layer of gauze or leno. It does not, like India rub-



ber sheeting, retain the secretions which may flow from the wound, and spread them over the whole line of suture, but permits them to flow through its meshes into the upper dressing of absorbent cotton, which may in some cases, if not all, be changed without disturbance of the gauze which protects the sutured surfaces.

The above therapeutic suggestions are offered by the editor (in place of more formal dissertations) in the belief that brief therapeutic hints are always welcome to the busy practitioner. Certainly the virtues of electricity are not fully utilized in the ordinary office practice of many physicians. For certain minor nervous and muscular affections of a painful nature, the battery is the proper remedy, and its quick results bring great credit to the practitioner.

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#### MARK TWAIN IN A NEW ROLE.

Those who have enjoyed the tonic effect of Mr. Clemens' best humorous stories and turned away in disgust from the inane absurdities which serve as padding in some of his books, will be somewhat surprised at his appearance in the new role of a serious investigator of psychological problems.

It seems that the phenomena of "telepathy" have arrested his attention. His energies are now to be turned to the collection of facts bearing upon that strange intercourse which is said to exist between the minds of sympathetic persons far removed from one another.

Now that scientific associations are taking up in earnest the investigation of ghosts and ghost-stories, there is no reason why they should continue to neglect the many alleged instances in which wives have been conscious of a strange sense of apprehension at the hour of the death of a beloved husband in some far-distant land, and such like.

The shivers which are ascribed to the fact that some one is walking over the as yet unselected burial plot of the shiverer, and the tingling in the ears which is popularly asserted to indicate that some one is speaking about you, might also be investigated.

We hope that Mr. Clemens' efforts, now that he is really going to be serious, may lead to something better than a mere collection of old wives' fables and striking coincidences.

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#### Reviews, Books and Pamphlets.

*The Physician as a Business Man; or, How to Obtain the Best Financial Results in the Practice of Medicine.* By J. J. TAYLOR, M. D. Philadelphia: *The Medical World*, 1520 Chestnut St. 1891. Price \$1.00.

We take pleasure in recommending this book to our readers. The problem which it seeks to solve is one which weighs more and more on the shoulders of the practitioner as he advances in age and begins to feel that his years of physical vigor are rapidly passing away, and that accident may possibly, and age will certainly, soon deprive him of his power to manage a large practice.

Dr. Taylor's little work considers the problem from every point of view and suggests to the physician many ways in which he may place his practice on a firmer and more sensible business basis,

*Age of the Domestic Animals.* Being a complete treatise on the Dentition of the Horse, Ox, Sheep, Hog and Dog, and the various other means of determining the age of these animals. By RUSH SHIPPEN HUIDEKOPER, M. D., Veterinarian (Alfont, France), Professor of Sanitary Medicine and Veterinary Jurisprudence, American Veterinary College, New York; etc. Royal Octavo of 225 pages. Illustrated with 200 engravings. Philadelphia and London, F. A. Davis, Publisher. 1891.

The anatomy, periods of eruption, and changes of the teeth, which are the chief index of the age of these animals, are carefully discussed and most beautifully illustrated. The author has drawn his materials from English, French, German and Italian sources, and from his own extensive experience. Price \$1.75 net, post-paid.

*Lindsay and Blackiston's Physicians' Visiting List for 1892.* 41st year of its publication. Philadelphia, Blackiston, Son & Co., 1012 Walnut St. Sold by all booksellers and druggists. The dated weekly form for 25 patients a week, price \$1, has just been received by us. It is bound in black leather and is neat and compact. Its special advantages lie in the list of newer remedies (a brief description of each being given) and the tables for examination of the urine. It contains, of course, carefully prepared dose-lists, tables of poisons and antidotes, sketches of the eruptive fevers, charts for calculation of term of pregnancy, etc. Monthly editions, weekly editions for different numbers of patients, and interleaved editions are also furnished at various prices.

*A Manual of Venereal Diseases;* being an epitome of the most approved treatment. By EVERETT M. CULVER, A. M., M. D., Pathologist and Assistant Surgeon, Manhattan Hospital of New York City, member of the American Association of Andrology and Syphilology, and late of the Department of Venereal Diseases of the Vanderbilt Clinic; and JAMES R. HAYDEN, M. D., Chief of Clinic Venereal Department of Vanderbilt Clinic, College of Physicians and Surgeons, New York. With illustrations. Philadelphia: Lea Brothers & Co., 1891. Extended notice of a book on such a topic from the firm of Lea Brothers & Co., is hardly necessary.

The work presents, as the preface promises, a working knowledge in very condensed form, of the three venereal diseases; gonorrhœa, chancroid and syphilis. Eighty pages are devoted to gonorrhœa; 70 to stricture; 17 to chancroidal sores; and 122 to syphilis. It is a useful monograph for those who wish to know the best practical methods now used in dealing with these important affections.

*A Practical Treatise on the Diseases of the Ear;* including a sketch of Aural Anatomy and Physiology. By D. B. St. JOHN ROOSA, M. D., LL. D., Professor of Diseases of the Eye and Ear in the New York Post-Graduate Medical School; Surgeon to the Manhattan Eye and Ear Hospital; Consulting Surgeon to the Brooklyn Eye and Ear Hospital, etc. Seventh revised edition. New York: Wm. Wood and Company, 1891. Illustrated.

The excellency of this work is sufficiently attested by the number of editions through which it has passed. Opening with an elaborate sketch of the history and literature of Otology, it proceeds to discuss the various disorders of the organs of hearing in such a way as to furnish a guide in practice to the advanced student and the general practitioner. Its author hopes that the work may not

be considered an elementary treatise, but may be found to contain much information needed by the most experienced specialist. Price in cloth, \$5.50; in leather, \$6.50.

*The Application of Sacral Resection to Gynæcological Work.* By E. E. MONTGOMERY, M. D., Philadelphia. Reprinted from *Trans. American Asso. Obstetricians and Gynæcologists*, 1891.

*Transactions of the Association of American Physicians; Sixth Session held at Washington, D. C., September 22, 23, 24 and 25, 1891.* The transactions of this association are always worthy of perusal, representing as they do work of the highest sort in practical medicine. The present volume seems to be quite up to the standard heretofore maintained.

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### Medical Progress.

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#### RENOVATION OF THE SLUMS.

Movements are now on foot, both in London and other large English cities, to increase the healthfulness of their slums by providing better dwellings for the poor. The movement is an exceedingly interesting one to sanitarians, and its results are being watched carefully. Sections are taken, the buildings condemned, paid for, and torn down. In their places decent ones are erected and rented at a cheap rate. Owing to the complicated method of governing London, by which the city proper has a sort of independent government within the regular city government, less of this work has been done there than in places where unity of action is more easily secured, but even there it is well under way.

Such work is most commendable in spirit, but it seems very questionable whether it will not be found that something besides a good house is required to elevate man morally. It is probably not one, but many things, which degrade men and women, and keep them so. There are those in England who claim that it would be far more effective in raising a degraded family to shut off their chance to get intoxicating liquor than to put them into a better tenement. Certainly the drunken habits of the majority of the slum dwellers, both in Europe and America, are well known. A curious confirmation of this was recently obtained in Manchester, England. While the matter of rehousing the poor in the celebrated "Ancoats" district, where some fifty thousand wretched people live, many of them dwelling in tenements, as stated by the members of the city council to be "absolutely unfit for human habitation," was being discussed, a gentleman connected with the United Kingdom Temperance Alliance offered a reward of five dollars for every case found where in a family neither the father or mother used liquor to excess. The challenge was accepted, but after long investigation not one could claim the reward.—Clipping in *Bulletin Tennessee Board of Health*.

#### INFLUENZA IN ENGLAND.

There is not much to record this week of the progress of influenza in this country. Whether the extent to which the metropolis suffered two years ago, and again last spring, has anything to do with the absence of any decided outbreak here at all commensurate with those in Edinburgh and Glasgow is uncertain. That there have for many weeks been several cases in London is undoubted, but happily the affection has not attained epidemic proportions. We note that the deaths attributed directly to influenza in London for the week ending Dec. 5th amounted to 9; in the previous week they were 13. The gen-

eral death-rate is still high at Newcastle-on-Tyne. In Cardiff it is estimated that 15,000 persons have been treated for it during the past fortnight; and at Newport many establishments have been closed in consequence. In Edinburgh the epidemic has assumed large proportions, the total number of deaths attributed primarily to the disease being, during the five weeks of its prevalence, as many as seventy-four. In the neighboring county of Fife there has been a heavy mortality. In Glasgow, Aberdeen and the neighboring districts, it is still very prevalent; and, as we mentioned last week, the disease has reached the remote Orkneys. On the Continent the chief centres appear to be Hamburg, Berlin and St. Petersburg.—*Lancet*, Dec. 12.

#### TO OPERATE ON THE OVARY WITHOUT DESTROYING THE PROCREATIVE FUNCTION.

It is gratifying to find that the best gynæcological surgeons are now looking about them for methods of operation which may free the ovary from cystic and other disease-growths without depriving the patient of the hope of offspring or reducing her to the very humiliating position of a castrated woman.

A description of a case operated on recently by Dr. T. Gaillard Thomas (*Med. Record*, Dec. 19, 1891), deserves insertion here as an illustration of what may be accomplished in this line:

A multipara, married three years, but never pregnant, came to consult me about October 1st of the present year on account of sterility, painful and irregular menstruation, pelvic neuralgia extending down the thighs, depression of spirits, persistent leucorrhœa, and impaired nutrition, which demonstrated itself by emaciation, or rather by the absence of all tendency to adipose deposits.

Upon opening the abdomen, the left ovary was found to be unattached by adhesions. It was as large as a small hen's egg, had a number of little peripheral cysts over its surface, and upon palpation presented unmistakable evidences of containing fluid of dense character. This ovary, with its corresponding Fallopian tube, was removed in the ordinary way. The superficial cysts were, apparently, due to dropsies of the Nabothian follicles. The centre of the ovary was occupied by a mass of black, grumous blood, about as solid as that which usually makes up the bloody material of a pelvic hæmatocele. This was the result either of an ovarian apoplexy, or of a small bloody cyst; I am decidedly of the opinion that it had the former origin.

The right ovary with a thick-walled cyst, which existed between itself and its ligament below and the Fallopian tube above, was firmly fixed by adhesions in the pelvis, and had to be enucleated, or "shelled out" by attachments with the finger.

The tumor depicted was one developed in the right broad ligament, and was firmly attached to the Fallopian tube above, and the surface of the ovary below.

*Operation.*—The patient was extremely desirous of becoming a mother, and I was very averse to following the usual practice of ligating the parts below the ovary and removing this organ together with the cyst and Fallopian tube. Instead, therefore, of doing this, I split the broad ligament with a bistoury guided by a grooved director, and at the expenditure of considerable time shelled out the cyst entirely and without evacuating its contents. Then I applied a half dozen ligatures of Chinese silk to the bleeding vessels, and with fine catgut closed the opening in the broad ligament carefully and completely.

Two cysts as large as cherry stones were found in the ovary. These were opened and their cavities lightly cauterized with Pacquelin's thermo-cautery

brought to a white heat. Then the Fallopian tube which, in consequence of these manipulations, had been broken completely away from the ovary, was attached to that organ by a strong catgut suture, the parts were returned to their normal places, and the abdominal wound was closed by silkworm gut.

The patient, as soon as ether narcosis had passed off, was made happy and hopeful by the announcement that the prospects of maternity had not been destroyed by the operation, but on the contrary, had been much increased. Upon receiving this intelligence she said, very promptly and decidedly, "Thank you for telling me this at once; now I shall surely get well, for I desire very much to live and am determined to recover. Had you confirmed my fears as to the result of the operation upon the prospects of having children, I should have been indifferent as to the end."

The steps of the operation, simple as they were, were very tedious, and over an hour was expended in their performance. Mrs. P—— made a rapid and easy recovery, and at the next regular menstrual epoch menstruated normally and painlessly, as I very confidently expected that she would do.

Although this case presents no features of great interest or moment, I report it as a contribution to the daily growing subject—the conservative surgery of the ovary. Certain I am that ten, or even five, years ago in my hands the ovary, which in this case has been saved, would have been destroyed; one more sterile female would have been added to the number daily created by the gynæcologist; and one more sorrowing and disappointed woman made to swell the already long list of those who bemoan a childless existence.

#### THIRD DENTITION.

The *American Journal of Dental Science* reports that Captain William Bruce, aged eighty-two, living at 1025 Valencia street, San Francisco, has just cut his third set of teeth. The captain is an old and well-known resident of the city, and his case has occasioned much interest.

For more than twenty years, Captain Bruce says, his gums were compelled to do the work of mastication. Between two and three years ago he began to be troubled by sharp pains in his gums, which continued at intervals day after day. He was at a loss to account for this, nor were the medical men whom he consulted able to give any explanations or relief. Finally, one bright morning, on making a careful examination, he was astonished to find the point of a white molar introducing itself for service from his tender gums.

Gradually it forced its way out, and soon began to assume respectable proportions. This extraordinary and unexpected visitor explained, in a measure, the suffering which its owner had been compelled to endure; and but for the fact that the pains continued after the tooth had fully appeared, he would have concluded that it was the only one with which he was to be blessed.

The growing process, however, was much slower than in the case of teeth-cutting with children, but it proved to be just as sure. Another molar on the opposite side of the mouth next popped out; then came a couple of incisors, then the canine teeth and bicuspid, until at last he has two shining rows of teeth as perfect, if not quite as large, as any owned by men but half his years.

The teeth made their appearance at intervals of from one to two months duration, and, as may naturally be supposed, much merriment was occasioned among the friends of the old gentleman when word was passed around among them that "the Captain's got another tooth." An examination shows the teeth to be firmly set in the gums, if not in their proper foundation in the jaws, and that they will, in all probability, serve him well for the remainder of his years.

## GENITAL CHANCRES IN WOMEN.

In an article upon this subject (*N. Y. Med. Jour.*, January 2, 1892), Dr. Taylor says:

Chancres in women are far less regular in their course than they are in men. In many women the chancre is so small, benign and ephemeral, that it may never be seen, or, if seen, its nature is usually not suspected. In very many cases, even when the lesion is strikingly apparent, its nature remains for a long time in doubt owing to inflammatory complications and to a want of striking individuality in the lesion itself. Then, again, simple inflammatory processes and chancroidal ulcers often become upon the female genitals so complicated and obscure in appearance that they may resemble specific lesions. In women, induration as a symptom is not so generally observed as it is in men. In some females it can scarcely be appreciated by careful examination, and it may be very transitory in its duration, whereas in others it attains large proportions, lasts for indefinite periods, and may lead to ultimate deformity. In men the chancre is readily examined. In women this lesion, owing to the nature and inaccessibility of the parts, is very difficult of examination except on protruding portions of the genitals.

The main reason why chancres in the female are so little understood, are so frequently unrecognized, and generally offer so much difficulty in diagnosis, is that there is very little chance for their study on a large scale, and faithful pictures of them are not obtainable.

As in men so in women, the chancre is simply a localized aggregation of a peculiar new specific cell growth. For clinical purposes we may divide genital chancres in women into the following varieties:

1. The superficial or chancrous erosion.
2. The scaling papule or tubercle.
3. The elevated papule or tubercle (exulcerated), *ulcus elevatum*.
4. The incrustated chancre.
5. The indurated nodule.
6. The diffuse exulcerated chancre.

After describing at length each of these forms of chancre he continues:

As a rule, all chancres of the female genitals are unaccompanied with pain. In some cases itching and burning are complained of, and in some chancres of the clitoris and fourchette severe pain is felt.

On the labia majora we find the incrustated chancre, the chancrous erosion, the *ulcus elevatum*, the diffuse exulcerated chancre, and the indurated nodule. In the tissues of these parts indurating œdema is very often observed as a complication involving large and small portions. This complication is also found as a result of secondary lesions—such as erosions and *condylomata lata*.

On the labia minora the chancrous erosion, the *ulcus elevatum*, and the diffuse exulcerated chancre are commonly found. All chancres on these parts may be accompanied by mild or dense induration, which may involve part or the whole of the structure.

Chancres of the fourchette are of the erosive, incrustated, or diffusely indurated type.

Chancres of the introitus vaginae, meatus, and myrtiform caruncles are commonly ill-defined masses of induration which frequently present no characteristic appearance, and whose diagnosis is usually very difficult, and frequently only possible after considerable delay and observation. On these parts it is very difficult, often impossible, to determine the extent and density of the induration.

Chancres of the vagina are very rare. Clerc never saw one, and Fournier says he never saw one seated beyond the vagina ring. Bockhart reports a case of chancre of the middle portion of the vagina which had developed upon an excoriation produced by a tickler in ultra-libidinous coitus.

In the treatment of chancres in women too much attention cannot be paid to the matter of cleanliness and to the production of a dry state of the parts. In some mild cases of chancre simple lotions only are necessary. When the lesion is well developed it should be constantly covered with mercurial ointment.

#### CHEYNE-STOKES RESPIRATION.

From the *N. Y. Med. Jour.*, January 2, 1892, we extract these paragraphs upon this interesting subject:

Dr. Boyd writes to the *Dublin Journal of Medical Science* that he has observed the following phases of the respiratory phenomenon:—

1. An apnœal period characterized by deep sleep, lividity of face, quick pulse, feeble contractions of the heart, and perfect rest from all agitation, mental and bodily.

2. An inspiratory period, with rousing of all the patient's faculties, extreme restlessness, showing and strengthening of the pulse, apparently stronger contractions of the heart, less lividity of the face, and then a final deep inspiration.

3. An expiratory period, with inspirations gradually getting shorter and expirations longer, pulse getting quicker and heart feebler in its contractions till expirations cease, the chest is empty, and restlessness gives place to sleep, which continues through the apnœa following.

The cardiac conditions necessary for the production of this form of breathing are, according to his experience, not alone dilatation of the aorta, but also dilatation of the right ventricle, with beginning degeneration or weakness of its walls, also hypertrophy of the left ventricle with or without dilatation, but with degeneration of its muscles or its dynamic contractile power enfeebled from any cause whereby it is unable to empty its contents into a dilated and inelastic aorta. He admits that this condition of the heart is often met with in many cases of valvular disease accompanied by atheroma of the arteries, and only produces dyspnœa. But the difference, he holds, is only one of degree. Any attack of cardiac dyspnœa produced by such alterations in the heart and aorta may become Cheyne-Stokes dyspnœa when any additional strain is put on it, so as to still further enfeeble its action and cause interference with the supply of arterialized blood to the respiratory centre. The affection is, in fact, cardiac dyspnœa plus poisoning, or starvation of the respiratory centre. Poisoning of this centre or interference with its blood supply may, of course, occur without cardiac disease, and give rise to Cheyne-Stokes respiration. Apoplexy, meningitis, and uræmic coma may be mentioned as conditions in which the phenomenon has been observed. Its occurrence, however, is undoubtedly favored by the changes in the heart substance described above by the author.

#### ELECTRICITY IN THE TREATMENT OF UTERINE FIBROIDS.

In giving his personal experience upon this subject before the American Electro-Therapeutic Society, Dr. Kellogg (*Jour. Amer. Med. Assoc.*, Jan 9, 1892) says:

To get good results from electrolysis it is necessary to observe the most scrupulous care, not only in the application of the electrical current, but in the after-management of the patient. When gynæcologists send patients off to

their homes on a street car, in a carriage, or on a railway train, a distance of two to twenty miles, after the application of 100 to 300 milliampères of current, it must not be a matter of surprise that now and then bad results are experienced. It is my custom to send patients to bed for twenty-four hours after each application of the current.

Another cause of failure in the employment of electrolysis, is neglect to use such other means as are known to be serviceable in the management of these cases. I do not think it the duty of the surgeon to neglect to employ for his patient whatever remedy he believes may be beneficial, simply for the purpose of enabling him to differentiate more exactly the results of his therapeutic efforts. I have met a number of cases in which the hæmorrhage, while not readily controlled by electrolysis, speedily yielded when ergot in efficient doses was added, although previously the employment of ergot had been ineffectual. I have employed hydrastis with success in similar cases, and also invariably resort to the use of hot vaginal douching, employing alum and other astringents, both with the douche and the tampon.

In hæmorrhage cases, I invariably begin by thorough curetting of the endometrium, which enables me to secure much more marked and immediate results than if the electrolysis alone is employed. I find also that by this means the disposition to increase of hæmorrhage, which is often noticeable at first when electrolysis is employed alone, is wholly avoided.

The hygiene of the patient, and all measures calculated to improve the general health, must receive careful attention.

In the study of the action of the electrical current, I have become more and more satisfied that its chief curative action in these cases is through its cauterizing effect upon the endometrium. The benefit often obtainable in these cases by thorough curetting has long been recognized. Electrolysis accomplishes the same results, not so rapidly, but more efficiently, in that its action penetrates the uterine tissues to a greater or less extent, according to the strength and the duration of the application. In one case a tumor which reached nearly to the epigastrium, of many years' standing, diminished more than one-half in size within three months as the result of two or three applications of the current. After the third application, in which a current of a little more than 300 milliampères was employed, the patient suffered a severe attack of phlebitis, not only in the tumor, but extending into one limb. For several days the patient was so ill I despaired of her life. She made a good recovery, however, and is well to-day.

Several other similar experiences, in which the symptoms were not so violent, however, together with the fact that the greatest improvement noticeable is in cases of sub-mucous and interstitial fibroids, have convinced me that the current acts chiefly through its polar, rather than by any subtle interpolar action. Interpolar action of the current must, necessarily, be transitory, whereas the destruction of tissue produced by the cauterizing action of the positive pole, which I use exclusively in the treatment of this class of cases, is something tangible, efficient and permanent in character, as the result of which blood-vessels are plugged by coagulation, and afterwards permanently closed by cicatrization, and thus the nutrition of the morbid growth materially lessened. My constant observation has been that a tumor, to be benefited by electrolysis, must be of such a nature and located in such a manner as to be influenced by an impression upon its vascular supply, such as described.



## DANGERS OF ANALGESIN.

The celebrated surgeon, M. Verneuil, has just made a communication to the Paris Academy of Medicine regarding the dangers which may attend the use of analgesin. The drug was injected into two patients suffering from sciatic neuralgia. The injection was made at the base of the toes. After the third injection gangrene suddenly supervened, and there was great difficulty in saving the lives of the patients. M. Verneuil attributes the gangrene to the disturbance in the nutrition of the organs caused by the chronic neuritis of the sciatic nerve.—Correspondence of *Amer. Lancet*.

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**Medical Items.**


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The salts of strontium, particularly the lactate, are said by Drs. Dujardin-Beaumetz and Paul to diminish albuminuria about one-half.

Dr. J. E. Michael has removed his office and residence to 201 W. Franklin St., formerly occupied by the late Dr. Christopher Johnston.

The Drevet Manufacturing Company, agent for Charles Marchand's peroxide of hydrogen preparations, has removed from 10 W. Fourth St. to 28 Prince St., New York City.

Warming rooms (*Wärme-Hallen*) for the poor have been opened in Berlin this winter, and seem likely to prove a great boon. The rooms, or rather halls, are open—gratuitously of course—from 8 A. M. to 7 P. M. Tea, coffee, with bread, soup, etc., are sold at cost price.

The method of purifying water invented by Dr. Wm. Anderson, and now employed at Antwerp with success, consists in passing the water through a revolving cylinder containing metallic iron in the form of scraps or filings. The estimated cost of purifying 1,000,000 gallons in this way is about 6s.

Dr. G. L. Walton has found that out of 1,000 children, taken consecutively at random from all classes of society, 11.1 per cent. have been found to have a history of infantile convulsions. Among epileptics whose epilepsy did not begin in infancy, seven per cent. had infantile convulsions.—*Med. and Surg. Rep.*

Dr. Tetzl (*Norsk Magazin for Lægevidenskaben*, No. 4, 1891) recommends the local application of the solution of chloride of iron to the ulcer in soft chancres, three to five days in succession, when the ulceration speedily changes to a healthy wound-surface. If one then dusts the resulting sore with calomel it soon heals over.—*Cincinnati Lancet-Clinic*.

The Medical Society of the State of New York will meet at Albany, February 2, 3 and 4, 1892. The following gentlemen have been appointed the business committee: Seneca D. Powell, M. D., No. 12 W. 40th Street, New York; James D. Spencer, M. D., Watertown, N. Y., and Franklin Townsend, Jr., M. D., No. 2 Park Place, Albany. Any communication regarding papers or any matter pertaining to the business of the society, which should properly come before the business committee, should be addressed to Dr. Seneca D. Powell, 12 W. 40th street, New York City.

Chemistry has once more been called in to detect a new adulteration in coffee,

This fraud, though only practised to a limited extent, is sufficiently ingenious. It consists in adding to a certain proportion of sound coffee beans a quantity of berries already exhausted in the manufacture of "coffee extracts." These useless berries are roasted, with a little sugar added to give the requisite brown tint.

The Directory for Nurses of the Medical and Chirurgical Faculty, located at the N. W. Cor. Saratoga and St. Paul Sts., and open from 12 to 6 o'clock daily, is now under the charge of Dr. C. Hampson Jones, whose office is at No. 25 W. Saratoga St. Dr. A. K. Bond has no longer any connection with the Directory and can give no information in regard to the securing of nurses.

Cleveland has an epidemic of impetigo contagiosa. It prevails all over the city, and in some quarters has caused some needless, albeit natural, alarm. It is a mild, self-limited, pustular affection of the skin, and attacks adults as well as children. It shows itself in the form of large, flat, superficial crusts, chiefly on the lower portion of the face and hands, and to a less degree on the covered portions of the integument.

The American Public Health Association will meet next year in the City of Mexico, under the presidency of Dr. Felix Formento. On motion of Dr. H. B. Baker, it was resolved to meet in 1893 in Chicago, in the hope of making the meeting an International Congress of Hygiene and Public Health. It is said that the entertainment arrangements by the hospitable people of the great West seriously shortened the scientific work.

Dr. Robert W. Johnson, of this city, has been elected to the chair of Principles and Practice of Surgery in the Baltimore Medical College, and, we understand, will at once enter upon the duties of the position to which he has been called. Dr. Johnson is a graduate of Princeton and the University of Pennsylvania. He has practised his profession in this city during the past 15 years with distinguished success. He has enjoyed a large experience and training in surgical work and brings to his college work the energy and experience required of the successful teacher and surgeon. Both the Faculty of the College and Dr. Johnson are to be congratulated on the appointment. Dr. J. D. Blake, who has filled the chair of Surgery since the death of Dr. E. R. Walker, has been elected to the chair of Operative and Clinical Surgery, the chair of Surgery being now divided as above indicated.

The editor of the *American Lancet* says: A party of Detroit capitalists have bought the right to use the Keeley cure for inebriety in Michigan. To these or their representatives only will Dr. Keeley sell his medicine throughout the great State. Thirty thousand dollars is the amount supposed to have been paid for monopoly. The company is said to have purchased a large property in the village of Northville, and arranged for the duplication of the state of things now existing at Dwight, Ill. It is surmised by the papers that over one hundred thousand dollars will be expended in the preparation of this plant for the cure of drunkards. From the character of the gentlemen composing this company it is certain that they are convinced that they have struck a method of making money better than United States bonds. Should Keeley sell his cure to each State on the same terms as he is said to have done to Michigan, he will have secured in this manner alone about one and one-half million of dollars. This is a nice little nest-egg for a poor physician. Besides this he has all the countries of South America, of Canada, of Europe, Asia and Africa, Australia and the islands of the sea with which to increase his nest-egg.

# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

- The Wood Corset; with Improvements, for the Treatment of Lateral Curvature and Pott's Disease of the Spine. By A. M. Phelps, M. D., New York. . . . . 265
- Case of Cerebral Hyperæmia Terminating Fatally. By Eugene L. Crutchfield, M. D., F. S. Sc., London. . . . . 272

### SOCIETY REPORTS.

- Clinical Society of Maryland. Stated Meeting held Dec. 18, 1891. After Inflammation—What? Dust as a Causative Factor in Pulmonary Disease. Elephantiasis Scrofuli. . . . . 277

### EDITORIAL.

- The Atmospheric Tractor and Uterine Safety Tube. . . . . 279
- The Hydratic Treatment of Typhoid Fever. . . . . 280
- Fees for Reporting Infectious Cases. . . . . 282

### REVIEWS, BOOKS AND PAMPHLETS. . . . . 282

### MEDICAL PROGRESS.

- The Dish-Rag Gourd as a Substitute for Sponges.—Medical Men as Health Inspectors.—Galvanism in Intestinal Occlusion.—A New Electrical Carriage. . . . . 283

### MEDICAL ITEMS. . . . . 285

## Original Articles.

### THE WOOD CORSET; WITH IMPROVEMENTS, FOR THE TREATMENT OF LATERAL CURVATURE AND POTT'S DISEASE OF THE SPINE.

BY A. M. PHELPS, M. D., NEW YORK.

The question of a suitable spinal support in lateral curvature of the spine and convalescent cases of Pott's disease has been before the profession from the earliest time, and not until Dr. Sayre devised the plaster-of-Paris corset did we have a brace that accomplished nearly all that is desired in a support.

The plaster-of-Paris corset I believe to be one of the most efficient supports. It certainly has the advantage of cheapness, and it is well adapted for use in clinics and dispensary practice. It has, however, the disadvantage of weight. Steel braces have been made. Many of them, when suitably applied, furnish very good results. Dr. Vance has constructed, to take the place of the plaster-of-Paris corset, a paper corset.

If the profession could have at their disposal a corset which combines strength, durability, porosity, and lightness, it would meet a long-felt want. I had heard something of the wood corset, but knew nothing of its construction. Therefore, three years ago I visited Europe for the express purpose of learning the details of its construction. On my return, I presented the corset at the New York Academy of Medicine, Surgical Section.

I visited Dr. Waltuck, of Odessa, Russia, and from him personally I learned

the details, after several days of hard work. I found that Prof. Lorenze, of Vienna, had been using the corset for some time, and was much pleased with it. At that time, however, many of the corsets proved to be inefficient on account of errors in their construction. We have used the corset constantly since that time, and with the modifications which we have made, it is the most efficient, comfortable and suitable spinal brace that I know of.

It has been with the greatest difficulty that we have succeeded in getting the proper materials for constructing the corset, and even now it is cheaper and better to import the wood from Vienna. The spruce timber which grows there makes a better shaving than any timber that we have attempted to use which grows in America. It is tougher, and works better with the glue.

The materials necessary for making the wood corset are: One dozen plaster-of-Paris bandages, one tight-fitting shirt, fifty pounds plaster-of-Paris, two pounds oakum, two yards of raw unbleached linen, a blue pencil, one pound of Cologne glue, a little glycerine, a knife for splitting wood, a glue-pot, a hammer, a large clothes brush, some towels, two sand-bags, a quantity of wood shavings, some shellac, an eyelet punch, a number of eyelets, and hook lacings, and two yards of knit shirting.

All of these articles are kept in stock by Messrs. John Reynders & Co., 303 Fourth Avenue, New York, who have kindly imported for me such materials as could not be produced in New York.

*The details of the work.*—Suspend the patient after the tight-fitting shirt has been applied. Indicate with the blue pencil mark around the body on the shirt, the length of the corset desired. Apply the plaster-of-Paris bandages as in making an ordinary plaster-of-Paris corset. When the plaster is set, remove it from the body by cutting it down in front. Strip out the shirt from the corset, when the blue pencil marks will be seen on the inside of the plaster corset. A few turns of the plaster bandage around the plaster corset is necessary. Put in a large dish a quantity of oakum picked up finely. Mix with this a quantity of plaster-of-Paris. After having greased the inside of the corset with vaseline, stir water into the plaster-of-Paris and oakum until it is of the consistency of thick mud. Apply this over the inside of the corset to the thickness of three inches. After it is set, remove the corset, and a perfect cast of the body will be the result. The blue line will be transferred from the plaster mould to the cast. The oakum is put in the plaster to facilitate the modelling, and also to make the cast tough, because considerable hammering has to be done upon it. The cast should

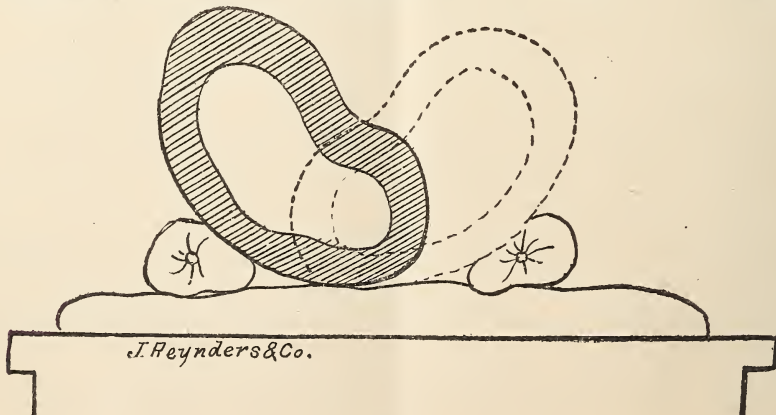


Fig. 1.

dry two or three days in a temperature not exceeding one hundred and fifty degrees. Any imperfection in the cast should be remedied with plaster-of-Paris, building out such points over the breast and hips and deformed portions as may seem necessary to make an artistic corset. Cover the cast with raw linen which has been wet for the purpose. Some difficulty will be experienced unless the workman has seen the work done.

The cast is placed on a table with the sandbags, as seen in Fig. 1.

The wood from which the corset is made is taken from the edge of a plank, the grain of which is as seen in Fig. 2. Fig. 3 shows imperfect grain. The

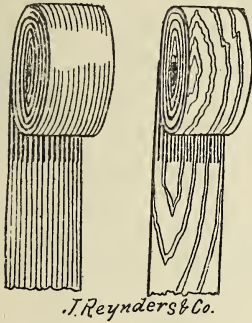


Fig. 2.

Fig. 3.

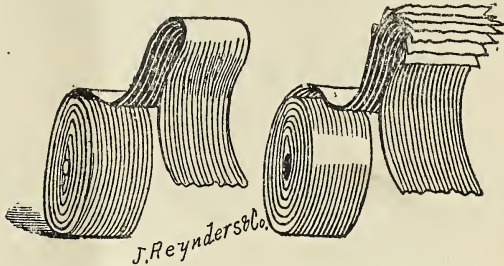


Fig. 4.

Fig. 5.

grain running as in Fig. 2 makes a tough strip that will bend as seen in Fig. 4.

When the grain runs as in Figs. 6, 7, and the wood is bent, it will present the appearance of Fig. 5, which has an element of weakness.

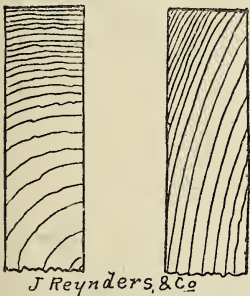


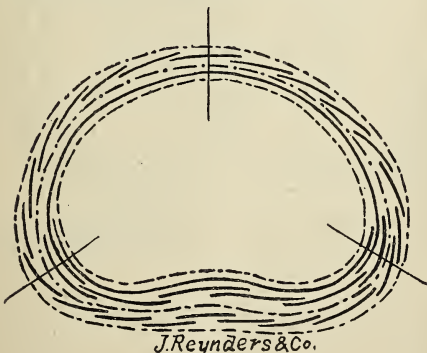
Fig. 6.

Fig. 7.

The layers of wood and linen are explained in Fig. 8, the dotted lines being linen, the black lines wood, and it will be seen that there are three layers of linen and two of wood in the front of the corset, with three layers of linen and three layers of wool in the back and side.

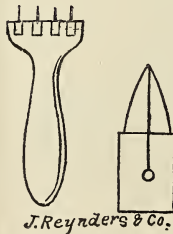
Over the hips extra pieces are put in, making it even thicker, which will be explained later.

The cast is now laid with the back up. Draw three longitudinal lines, one in the centre in front, and one on each side, dividing the cast into three equal



J. Reynders & Co.

Fig. 8.



J. Reynders & Co.

Fig. 9.

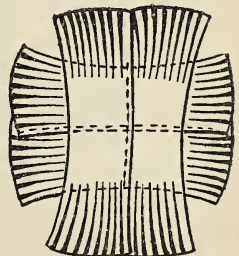


Fig. 11.

parts. Cut several strips of wood in lengths long enough to overlay the lateral lines two inches.

With the tool, Fig. 9, split the ends of the wood as seen in Figs. 10 and 11. The object of this is to allow the ends of the wood to spread or overlap, so as to

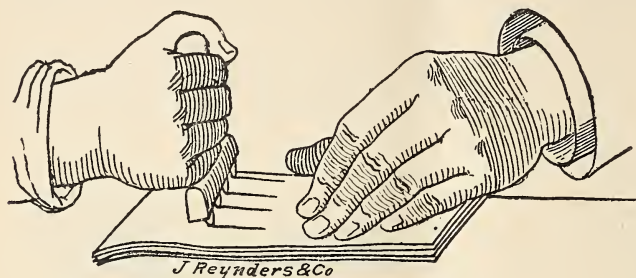


Fig 10.

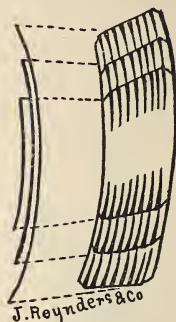


Fig. 12.

fit all inequalities, as seen in Figs. 11, 12, 13, 14 and 15. Prepare the glue by soaking it in water over night, then melt it. To a pot (holding one quart) of

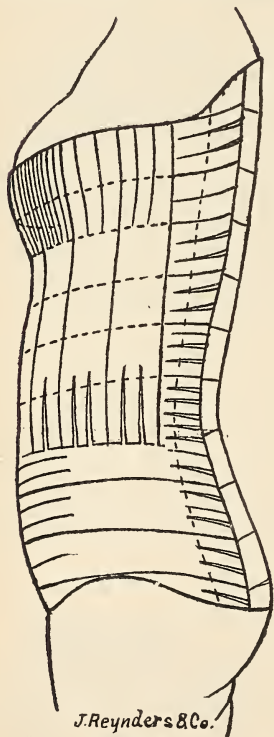
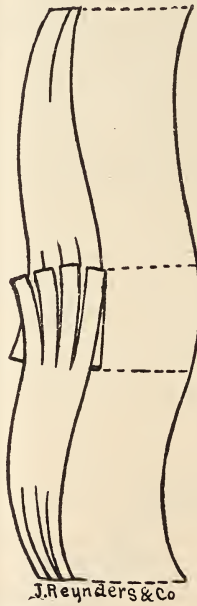


Fig. 13.



Figs. 14 and 15.

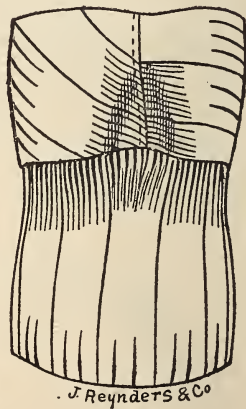


Fig. 19.

glue, add one tablespoonful of glycerine. Dip the glue-brush into the glue, wiping it as dry as possible on the edge of the pot so as to use the least possible quantity.

A strip of wood is covered with glue, and the brush drawn along the part of the cast where the wood is to be laid, beginning at the top of the cast with a transverse layer; strip after strip is applied, and overlapping the strip above

one-eighth of an inch. Cover this layer of wood with the linen and glue, and hammer the whole together. Turn the cast on the side, and working from the centre in front, put the strips on horizontally, overlapping the strips already laid on, two inches. Cover this with linen, lapping on the back two inches. Finish the opposite side in the same manner. See Fig. 16.

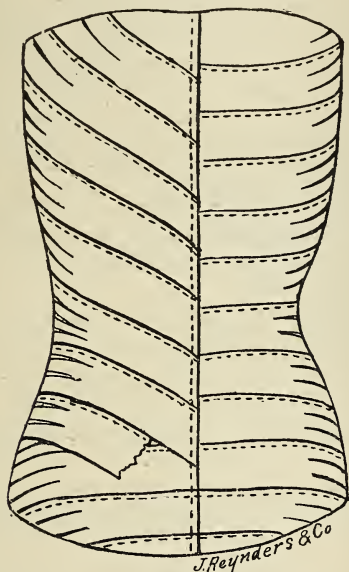


Fig. 16.

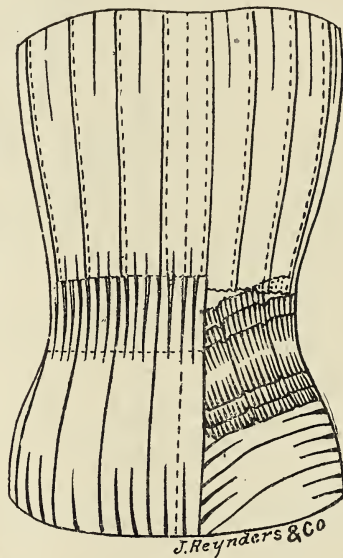


Fig. 17.

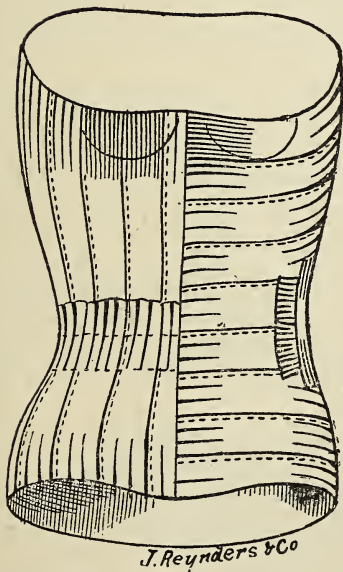


Fig. 18.

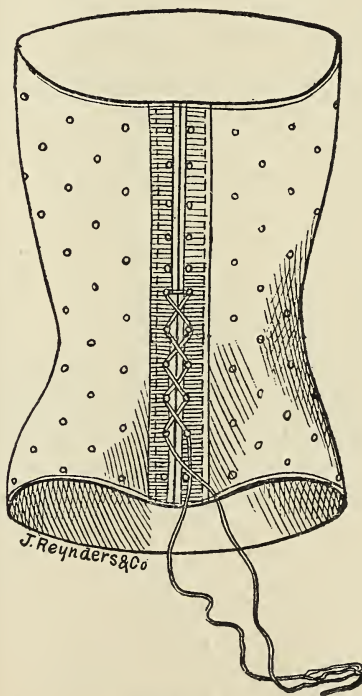


Fig. 20.

Beginning in the back, put on the strips longitudinally, overlapping four inches in the centre of the cast from the top and bottom. See Figs. 17, 18 and 19, left side.

Hammer the wood well together with an ordinary shoemaker's hammer. Now stay the corset with wood, as seen in Figs. 17 and 18, over the hips, and also strengthen the corset by putting on another layer of wood diagonally from the shoulder to the opposite hip, meeting at a point in the centre of the waist. Cover the entire work with linen, putting the least amount of glue on the wood before the linen is applied. After twenty-four hours the corset can be removed from the cast, fitted to the patient, and sent to the trimmer, who will treat it in the following manner. Corsets made according to the method followed at the time I observed the process were not as perfect as they should be.

1. The slightest excess of glue moistened by the perspiration of the body coming in contact with the shirt or the skin, was exceedingly disagreeable. 2. The perforations in this corset weakened them, and allowed the glue to exude during perspiration.

To obviate all this, I had the corset perforated, as seen in Fig. 20, in which perforations eyelets were punched. A special machine facilitates the perforating and punching of the eyelets. The lacings are stitched on as in Fig. 20. Trim the top and bottom with kid. The entire corset is shellaced inside and outside with two or three coats of shellac, which renders it impervious to moisture, the eyelets ventilating it perfectly.

A corset made as I have described, it will be observed, differs from that of Dr. Waltuck in the layers applied as seen in Fig. 18. It is no better, but somewhat easier to make.

The improvements which I have made in the corset consist in shellacing it on the inside and outside, and putting, in the eyelet holes, eyelets, which add to the strength of the corset and ventilate it perfectly.

An ordinary corset, for an adult, weighs from one to one and a half pounds. They are very durable, very comfortable to wear, and thus far I believe that they are the best spinal braces yet devised.

I have made from the paper used in the manufacture of boats, a corset which answers the purpose equally as well as the wood corset. It is much lighter, and seems to be as durable, and I am not sure but it will take the place of the wood corset. Time will determine. The process of making the paper corset is similar to that of making the wood corset, so far as making the cast is concerned, after which the cast is sent to the paper-boat manufacturer, who applies the paper according to the process employed in making boats.

Another use to which the wood shavings are applied is in working them with plaster-of-Paris in the treatment of fractures, osteotomies, or of excision of joints.

Being thin and narrow, they admirably adapt themselves to the parts, and the plaster-of-Paris holding them in place, they fit more accurately than any mechanic could shape a solid piece of wood to fit.

Again, roll two layers of crinoline, between which wood strips have been placed, as shown in Figs. 21 and 22.

Roll up four yards of this, as seen in Fig. 22. With a saw, cut this into rolls four inches in length. Immerse one of these bandages in water, and it will be found an admirable dressing when applied to a limb in cases of joint disease, or where a slight support is required to hold a limb in a proper position. The starch of the bandage soon hardens, so that we really have a starch bandage reinforced by wood shaving.



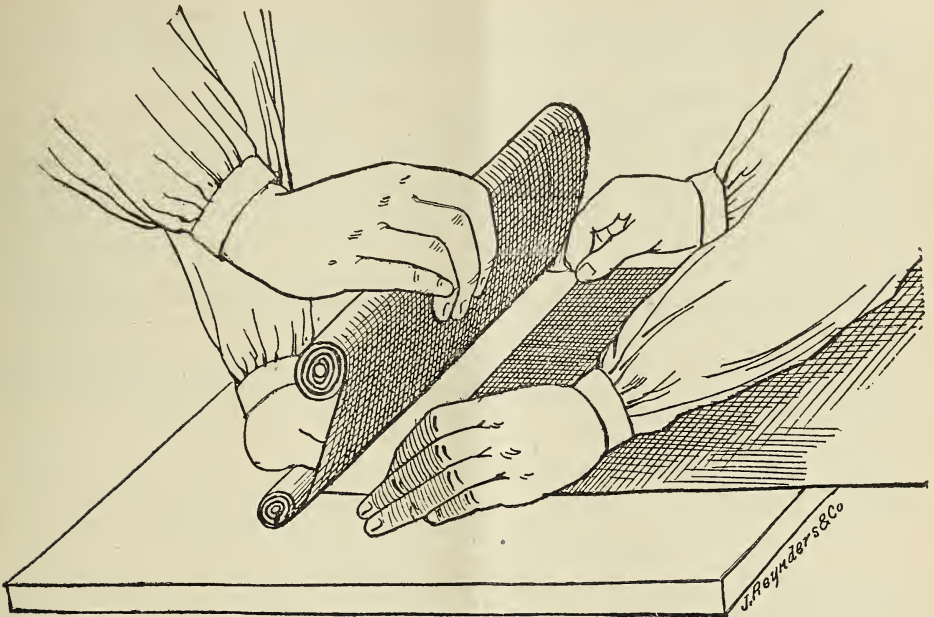


Fig. 21.

There are many cases in surgery where this bandage can be used to great advantage, and applied over surgical dressings it takes the place of plaster-of-

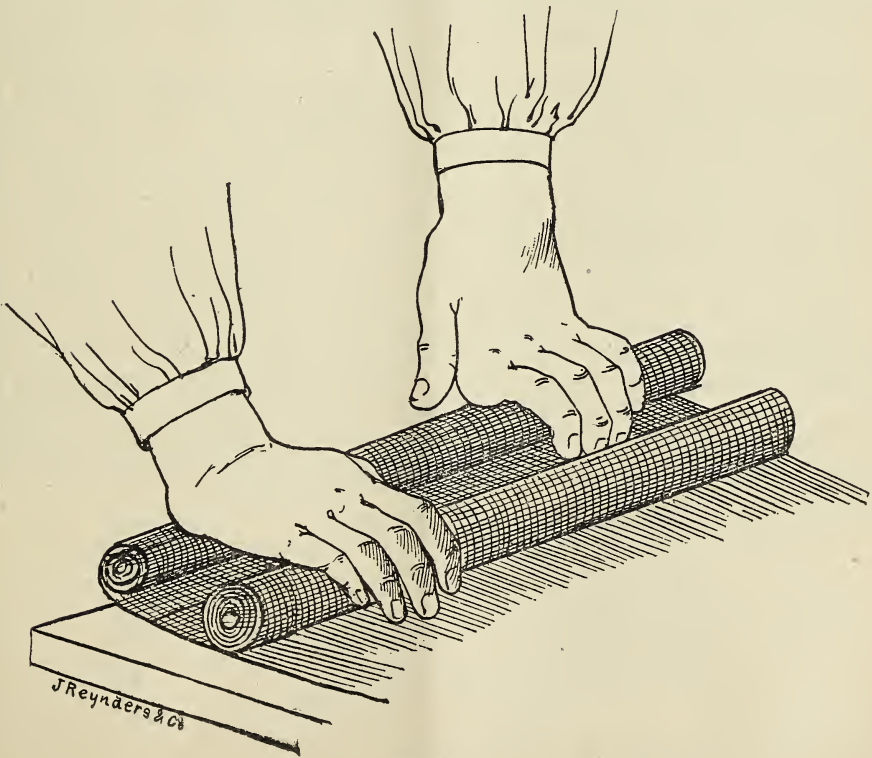


Fig. 22.

Paris. It is light and just as strong as plaster-of-Paris, and it has the advantage over the starch bandage of keeping its position after it is applied, even before it is dry.

The corset is somewhat difficult to make. It requires a good worker in wood and glue, and a plant for doing the work.

It would hardly pay a general practitioner, who possibly would not use more than four or five corsets during the year, to go to the trouble and expense of making his own corset. If those gentlemen who desire to use the corset will make a plaster-of-Paris cast as described in the beginning of this paper, and send it to the workshop of the Post-Graduate School and Hospital, the men there will make the corset, and Messrs. John Reynders & Co. will satisfactorily trim it.

I will say, by way of parenthesis, that the corsets, when completed, can be covered with silk or with stockinet, or they can be left in the linen finish. They are not so warm for summer use in the linen finish.

### CASE OF CEREBRAL HYPERÆMIA TERMINATING FATALLY.\*

BY EUGENE L. CRUTCHFIELD, M. D., F. S. SC., LONDON.

Member of the Clinical Society of Maryland.

On the morning of Saturday, October 24th, 1891, C. H. K., attorney-at-law, unmarried, aged 21 years and 10 months, while walking to his office noticed a peculiar blindness and a numbness in the right hand and arm. Vertigo was also present. He succeeded, however, in reaching his place of business, and after arriving there these symptoms became aggravated so that it was with the greatest difficulty that he could draw up some legal papers. Ataxic aphasia was another prominent symptom. By force of will he remained at his office until dinner-hour (1 o'clock). He then rode home. His symptoms had by this time somewhat abated, but the family at once perceived that something was wrong. In answer to his sister's inquiry he merely said, "I am sick." Being of remarkable fortitude, she knew that he must be very ill indeed to make any complaint. He then described to her his sensations during the morning. In order not to alarm the family, he tried to eat dinner with them, but in a very short time he was compelled to excuse himself. I was called to see him about 2 P. M. He was then suffering with excruciating cephalalgia and extreme nausea. The left eye was much injected and the pupil considerably dilated. There was numbness and partial paralysis of the right hand and arm. The tongue when protruded deviated to the right side. The carotids (and especially the left) throbbed violently. Ataxic aphasia shortly reappeared. The bowels had moved that morning. Hot pediluvia, made still more stimulating by the addition of mustard, were ordered. Sinapisms were also applied to the wrists, and later on to the epigastrium and the nucha. The following mixture was prescribed:

R̄.—Bismuth Subcarb.	. . . . .	3 ss.
Sodii Bicarb.	. . . . .	3 j.
Sodii Bromidi.	. . . . .	3 iss.
Ext. Ergotæ Fl.	. . . . .	3ij.
Mucil. Acaciæ	. . . . .	3 j.
Aquæ Menth. Pip. q. s. u. f.	. . . . .	3 iij.
M. Sig. 3 ss every hour.		

\*Read before the Baltimore Medical Association, December 14, 1891.

The vomiting became so violent that the stomach rejected everything, and being evidently of cerebral origin, this prescription was discontinued and for it I substituted bromide of lithium in ten grain doses, to be repeated about every thirty minutes. The cephalalgia and the nausea continuing with augmented force, I determined to administer chloroform, both for the purpose of alleviating pain and also because of its well-known power of producing cerebral anæmia. The family had urged me to give morphia hypodermically, but I positively refused to comply with their request, knowing that morphia tends to increase brain congestion. In its stead, I had given sulphate of atropia (grain  $\frac{1}{160}$ ) hypodermatically.

Under the influence of chloroform the pulse became stronger and the left pupil contracted. I then ordered that the bromide of lithium should be administered *per rectum*, about forty-five grains every hour. This treatment was continued without intermission for several hours. About 10 P. M. he commenced to yawn. Regarding this as an unfavorable symptom and knowing that the family would be better satisfied if there were another physician in attendance, I explained to them the circumstances. At their suggestion, Dr. Thomas P. McCormick was called in consultation. He confirmed the diagnosis of cerebral hyperæmia and approved of the treatment instituted. From this time he continued to see the case with me.

Chloroform was administered by inhalation, and enemata of bromide of lithium were given throughout the night. About 3 or 4 o'clock in the morning I noticed a slight elevation of temperature. Accordingly two rectal injections of phenacetine of about fifteen grains each were administered within a period of an hour. Perceiving that the patient was becoming worse and realizing that no time was to be lost, I had a cupper and leecher immediately summoned and six leeches applied to the nape of the neck and over the mastoid portion of the left temporal bone.

It would be tedious to go into the minutæ of this case. The following general observations will, therefore, suffice. The congestion which at first seemed to be confined to, or at least greater on, the left side of the brain, afterward became general, as indicated by the dilatation of the right pupil also and the profound coma which supervened. Consciousness was lost on Monday, October 26th, about 10 or 11 A. M., and this state of insensibility continued up to the time of death, Thursday, the 29th of the month, at 7 P. M. During this time urine and fæces were passed involuntarily.

The respirations became considerably increased in frequency. In regard to their character there was at times a faint approximation to the Cheyne-Stokes breathing. The heart also towards the close beat with great rapidity, reaching 150 pulsations in a minute. The pulse was compressible.

Abnormal sensibility to pain was quite prominent. At first, hypodermatic injections caused him no more distress than in the generality of persons, but on the second day they produced so much suffering that the patient himself inquired why it was, since they did not have the effect at first. Jactitation and singultus were marked and distressing features of the case.

Among the remedies employed, in addition to those already enumerated, were the following: For the vomiting, at different times liquor calcis and brandy calomel, dilute hydrocyanic acid, both *per os* and hypodermatically, and champagne. To produce derivation, calomel, oleum tiglii, an enema of sulphate of magnesium, cold to the head and warmth to the feet. To contract the arterioles of the brain, ergot under the skin and in the form of a clyster. For stimulation and nutrition, brandy, champagne, nitro-glycerine, and meat-juice.

Although the condition of the patient was that of extreme weakness, the pulse being compressible and the symptoms altogether denoting the utmost gravity, the administration of chloroform was continued at intervals until the morning of October 27th. In fact, I invariably noticed that the inhalation of this anæsthetic brought about such a change as to encourage both the physician and the family. The pupils would contract to their normal size and the pulse would become stronger. The obstinate vomiting was not deemed a contra-indication to its employment. I reasoned thus: This symptom was produced by the congestion existing in the brain. Chloroform would relieve this hyperæmia and, therefore, cure the nausea by removing the cause.

Gradually, however, his system ceased to respond to this agent and larger quantities were necessary to get him under its influence. Finally, on the morning above mentioned, while inhaling its vapors, the patient ceased to breathe. He was as still as one from whom the vital spark had fled. The pulse continuing to beat, I pulled the bolster from under his head and ordered that the body should be elevated. In other words, I resorted to Nélaton's method of resuscitation, and in a few minutes had the extreme satisfaction of witnessing a return of the respiratory movements.

From this moment to the time of his death nothing in the way of treatment was attempted. The stomach had ceased to absorb, as we had learned shortly before when an attack of vomiting coming on (the first in six or eight hours), everything that had been administered during that time was regurgitated. The bowel had become irritable so that medicines given that way were lost.

At this point the question as to the advisability of venesection in this case may with propriety be considered. This measure suggested itself to my mind, but I at once dismissed the idea. In my opinion it was decidedly contra-indicated. Blood-letting I believe to be in some cases a therapeutic means of great value, but I cannot think that in my patient its employment would have been advisable or even allowable. Even the most ardent advocates of the abstraction of blood contend, if I mistake not, that it should be practised only when certain conditions are present. It is recommended when the patient is robust, the action of the heart energetic, the pulse full and strong, and the vital powers capable of affording sufficient resistance to overcome the depressing effects of disease. My patient could answer to none of these requirements. In appearance he was rather tall and of very spare build, his health had always been delicate, throughout his whole life, his digestion had been poor, the pulse, as already stated, was compressible, and I firmly believe that although he died of congestion of the brain, his condition was that of spanæmia.

Dr. Wm. A. Hammond, in his work on "Diseases of the Nervous System," in giving the treatment of the trouble under consideration, says: "In the active form of this affection, the abstraction of blood was formerly very generally practised, but is now rarely performed. I have never seen a case in which it was required. Local bleeding is more generally applicable, and a few cups to the nape of the neck will often afford marked relief. Leeches to the temples are also useful, though they are preferably applied just inside the nostrils. I have many times witnessed the most satisfactory results from a couple of leeches thus used and from accidental nasal hæmorrhage." Dr. J. Lewis Smith says:\* "This treatment (that above mentioned) if employed early will relieve the congestion in a large proportion of cases, but if there be no improvement, if the child be robust, and if the primary affection be such as does not contra-indicate loss of

\*"Diseases of Children," 1881.

blood, leeches should be applied to the temples or some part of the head." He does not mention venesection, and it is to be noticed that he lays special stress upon the conditions under which even leeches should be applied. Rosenthal says:\* "The slight antiphlogistic medication above referred to will suffice when the irritative phenomena are moderate. The appearance of symptoms of depression or of stasis may demand copious venesection. This should only be performed if the patient is robust, the heart's action energetic, and the pulse full and hard. In old people with poor nutrition, and when the action of the heart is feeble, and the pulse soft and irregular, venesection is contra-indicated, and we must rely upon derivatives and revulsives."

Dr. W. R. Gowers† expresses the opinion that "venesection or leeching may be employed according to the severity of the attack; in active congestion the blood which is taken should be removed quickly. The relief which in such cases follows an epistaxis illustrates the value of this method of treatment. It is not advisable in those cases in which, from overaction of brain-tissue, or from cold to the surface, dilatation of the cerebral vessels results, while the face remains pale." According to the dictum of this eminent neurologist, bleeding was certainly contra-indicated in this case, for, as I shall presently show, the trouble was brought on by overaction of the brain-tissue, and during his entire illness the face remained pale. It is true that the late Dr. Austin Flint said‡ that "intense active hyperæmia calls for blood-letting;" but in another part of his work, in discussing the treatment of pleuritis he insists that this measure should be resorted to only when the patient is robust, the heart-action good, and when the disease does not tend to destroy life by asthenia.

Dr. Homer O. Jewett, of Courtland County, N. Y., in an able article entitled "The Use of and the Neglect of Blood-Letting," read before the New York Medical Association, Oct. 24, 1890, and published in *Gaillard's Medical Journal*, of February, 1891, thus epitomizes the whole truth: "The propriety of venesection in cerebral congestion or apoplexy must depend wholly upon existing indications in individual cases, and I have had no recollection when those indications were disregarded by intelligent practitioners. I have no experience with 'bleeding for a name instead of a condition.'" If what these men have said is true, then it seems to me there can be no doubt that I pursued the right course in not bleeding this young man. The question of blood-letting has thus been lengthily considered because it has been intimated to me that this was the only thing left undone and that it should have been tried.

The previous history of this patient is interesting in several respects. About eleven years ago he fell on the ice, striking his head upon the occiput. Some cerebral trouble (probably severe concussion, if the statements of the family are accurate) ensued. A few years later he was afflicted with alopecia circumscripta in the same spot that had touched the ground in his fall. For several years he had suffered greatly with headaches. In one instance, a severe cephalalgia was distinctly referable to excessive mental strain, as it came on directly after a series of examinations at school. While pursuing his legal studies he made frequent entries in his diary (as it was learned after his death) to the effect that he awoke with a bad headache, and that he feared he would be obliged to discontinue the study of law on account of these headaches. He also at times complained of a difficulty in collecting his thoughts. For several years he had been troubled with palpitation of the heart, sometimes brought on by the

\* "Diseases of the Nervous System," 1879.

† "Quain's Dictionary of Medicine," Article: Hyperæmia of the Brain.

‡ "Practice of Medicine," 1884.

gentlest exercise, and then again manifesting itself without any apparent cause. Impairment of vision had also been noticed for some time, and he frequently spoke of consulting an oculist. Had he done so, an ophthalmoscopic examination would probably have revealed his true condition. Irritability of temper was conspicuous. Dyspeptic symptoms, constipation and debility were marked features of his case. These facts show that a chronic hyperæmia of the brain had probably existed for several years. This was the premonitory stage described by Hammond.

Notwithstanding all this, and although he had a mind of more than usual intelligence, he continued to apply himself with untiring diligence. His indomitable perseverance and unbounded ambition ever urged him on in the pursuit of greater attainments. As Hammond has said, "Men who would readily see the impropriety of walking three or four miles while suffering with an inflamed knee-joint, do not hesitate to exert a disordered brain to the extreme limit of its power." This overtaking of the mind and constant worry about the most trifling circumstances we were forced to consider as the cause of the trouble. No other etiological factor could be discovered. The heart and the lungs were perfectly normal, and an examination of the urine showed that it was free from both albumen and sugar. The family, however, remembering the fall, the alopecia, and the frequent headaches, concluded that the fall must have been the *fons et origo* of the affection, and in order to determine this point requested a *post-mortem* examination. Owing to the interest attaching to the case, this request was readily granted.

The necropsy was made by my highly esteemed friend, Professor Alfred Whitehead, M. D., M. R. C. S., Eng., assisted by Dr. McCormick and myself. It revealed the following conditions:

Both hemispheres of brain much congested. Some meningeal inflammation secondary to the congestion. Weight of brain 48 oz. Lymph along upper border of each hemisphere. Sinuses engorged. Intense congestion of cerebral substance. Gray matter well developed. White matter deeply congested. Slight effusion in both lateral ventricles. Great engorgement of vessels in the vicinity of the ventricles. Choroid plexus quite congested. Slight congestion in cerebellum. No evidence of fracture, thickening of the membranes, or other ill consequences of the fall. Neither could we discover a rupture of a blood-vessel or an embolus. Our theory as to the etiology of the case was thus confirmed.

A word as to the age of the patient will not be inappropriate. If the cerebral hyperæmia so often seen during infancy and early childhood be excepted, the affection is more common in middle-aged or old persons. Gowers says that "age increases its frequency (but this is more true of the passive form); yet children, from the sensitiveness of their vaso-motor system, occasionally suffer from active cerebral congestion." It is, therefore, somewhat surprising that one of the age of my patient should have been thus carried off.

As none of the authorities that I have consulted state the mode of death from congestion of the brain, I will say that in this case it was by apnoea.

1601 Eutaw Place, Baltimore.

The *British Medical Journal* says that the municipality of Seville has decided to establish two public pharmacies where poor patients may have prescriptions made up for nothing. All of the local druggists are up in arms against the proposal.

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**Society Reports.**

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## CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DEC. 18, 1891.

The 259th regular meeting of the Society was called to order by the President, Dr. Robert Johnson.

*Dr. C. W. Mitchell* read a paper entitled AFTER INFLAMMATION—WHAT?

*Dr. Wm. B. Canfield* read a paper on DUST AS A CAUSATIVE FACTOR IN PULMONARY DISEASE. The various kinds of dust may be divided into animal, mineral and vegetable. Opinions differ as to which kinds are most dangerous when inhaled. That which is generated in brush factories is animal and very harmful. Makers of hats, especially felt hats, suffer much from the dust evolved. The vegetable dust that does the greatest and most lasting injury to the lungs is that generated in tobacco factories. This dust has not only a mechanical action but has also poisonous effects. It is in connection with the inhalation of mineral dust that the greatest amount of scientific investigation has been made, especially in relation to the diseases called the consumption of grinders, miners, potters, etc. Anthracosis, silicosis, siderosis, chalicosis, tabacosis and other kindred names have been suggested to describe a similar condition produced by various kinds of dust. Zenker has handed down the word "pneumonokoniosis" to cover all these conditions. The history of these cases is very much alike. They begin with simple bronchitis, which gradually becomes chronic. They are usually non-tuberculous, at least at the beginning; tuberculous complication is only an accident.

Where one is exposed to an atmosphere of dust the contact of this dust with the sensitive nasal and laryngeal mucous membrane sets up coughing and sneezing and much of the dust is expelled, and for a time no harm results; but a continued exposure to this dust causes a congestion of the mucous membrane of the nose and breathing passages, and, in time, an inflammation of the whole tract; the ciliated epithelium loses its power and dust finds its way to the ultimate ends of the lung tubules. When the individual is asleep or absent from this irritation, the ciliated epithelium gets rid of a large part of this foreign substance and the wandering cells may close around some of this dust and try to carry it off or render it harmless by burying it in a lymphatic gland. Much, however, finds its way either through the epithelium or between the cells into the submucous layer, getting into contact with the connective tissue of the alveoli and by irritation causing a hypertrophy of this tissue and a condition resembling chronic interstitial pneumonia or fibroid phthisis. The general opinion seems to be that the fibroid condition seems to oppose a direct barrier to the growth and multiplication of the bacillus tuberculosis, and in large tracts of lung tissue converted into this material often not a bacillus could be detected. In one of the author's cases, bacilli were found in abundance and yet two years afterward the man reported himself as entirely well.

The color of the expectoration is a prominent sign in these cases. In one case of the author, a stoker, the expectoration still continues absolutely black at times, and always tinged, although it is almost two years since he gave up his occupation. Examination of this sputum under the microscope showed it to contain in abundance carrier cells, which in all cases contained pigment and in some instances the black crystalline coal could be recognized within these cells. **This pigment and foreign material has a tendency to collect at the apices of**

the lungs and is only present at the bases when the dust inhaled is excessive in amount and exposure prolonged.

In diagnosis, physical signs do not yield as much as the microscope. By the microscope we see the cells containing the dust. In the author's cases the râles were heard on auscultation but nothing marked was obtained on percussion.

The prognosis is good if the man has not worked too long at the occupation.

The treatment is to take the patient from his dangerous occupation, when improvement begins at once. Owners of large factories are adopting stringent prophylactic measures in order that they may not lose so many good workmen. The best methods are: 1, to prevent the formation or escape of dust by using wet grinding or by grinding in closed vessels. This is not always practicable. 2, to prevent inhalation of dust by wearing respirators, etc. But these are uncomfortable and the men remove them at every opportunity. 3, the removal of dust as fast as it is produced by using fans and air shafts. This is, by far, the best plan.

Still further, the following rules should be enforced: 1, workmen should change their outer clothing after work; 2, they should keep their face and hands as clean as their work will allow; 3, they should never be allowed to eat in the workroom.

*Dr. Randolph Winslow* related A CASE OF ELEPHANTIASIS SCROTI. (See page 221, Jan. 9, 1892.)

1603 N. Broadway.

WM. T. WATSON, Secretary.

#### CALCULUS IN AN INFANT.

At a recent meeting of the Academy of Medicine (*Cincinnati Lancet-Clinic*, Jan. 2, 1892) *Dr. Evans* reported the following case:

Patient, a male child one year of age. The parents stated that the child had not urinated for twenty-four hours, which I doubted, but recalling the fact that the parents could tell positively by the child's wearing apparel whether or not it had passed urine in a given time, I was more disposed to give credit to their statements. On examination I found the bladder above the umbilicus. I then palpated the penis and urethra, but could not make out anything. I used an infantile catheter (*Utzmann*) and found a stone in the membranous portion of the urethra. The catheter was passed on into the bladder and the urine allowed to escape. I show here the instrument; its chief peculiarity is the sharp curve similar to that found in a catheter for cases of enlargement of the prostate. Here the high position of the infantile bladder necessitates the same curve as does the enlarged prostate.

The next day the mother called my attention to a swelling at the peno-scrotal angle which was distinctly outlined. I left it alone, expecting it to pass down to the meatus, but it did not. I removed it by passing a curved probe around it and drawing it forward to the meatus, where it was easily removed by slitting up the meatus.

The calculus is round, the size of a buck-shot, and is composed of uric acid.

For the removal of the iodoform odor from the hands and from utensils, *Bienert* recommends washing once or twice with linseed oil and water. The odor is said to disappear with surprising quickness.—*Pharm. Centralhall.*



**THE MARYLAND MEDICAL JOURNAL.**

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

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BALTIMORE, JANUARY 23, 1892.

**Editorial.****THE ATMOSPHERIC TRACTOR AND UTERINE SAFETY TUBE.**

We have just received a pamphlet concerning these inventions. Also a personal letter from the doctor who invented them, in which he asks whether it is not about time that we brought the merits of the said instruments before our readers. He furthermore states that his discoveries will remove from obstetrics the reproach that it "is lagging behind," and will place it on "a scientific basis."

In reply, we would state that we have hesitated heretofore to notice the invention because we do not wish to criticise unfavorably unless duty compels us to make such comment. Being called to account for our silence we need not hesitate longer to give our opinion.

The *atmospheric tractor* is intended to assist delivery of the child in parturition. It consists of a rubber concave disc, which is applied closely to the scalp or skin of the buttocks of the child. This was, we believe, formerly pressed on tightly by the fingers of the doctor; but now it is made to adhere by exhaustion with an air pump. Extractive force is said to be exerted in two ways; first, by traction on the rubber tube, which connects the disc with the air-pump (just as the boy raises a stone by drawing on a string attached to the stone by a bit of wet leather); and secondly, by the removal of atmospheric pressure from in front of the child's head or buttocks, which the inventor thinks is secured by his apparatus. It is a pity that he should have wasted time and money on such an invention. The introduction of a rubber disc into one vagina after another is an extremely bad form of "meddlesome midwifery" and is contrary to all principles of asepsis. The traction on the rubber tube would not amount to anything in a retarded labor.

The removal of the atmospheric pressure from before a presenting head could only be secured by closing the outer opening of the vagina and pumping out the

air which the vagina contains. This would result in injurious, perhaps fatal, hæmorrhage from vaginal and cervical vessels. The exhaustion secured by the present apparatus could only extract the brains of the child if its centre were over a fontanelle, or a little meconium if it were placed on the buttocks (breech presentation) with its centre over the anus.

The *uterine safety tube* is perhaps a more dangerous bit of apparatus than the atmospheric tractor. It is essentially a soft catheter which is to be introduced during labor past the head into the uterine cavity. The argument on which this procedure is based, as set forth in the pamphlet, is one of the most extraordinary bits of error which we have ever read. The inventor believes that the power which expels the fœtus in labor is the force of *super-heated air* which is collected in the womb behind the child's body and expands with an alleged rise of temperature in the womb during labor. Accidents from impetuous expulsion of the child are to be prevented by *drawing off* the excess of this "super-heated air," by means of the "safety tube." The effect really produced is that a natural labor is made by the meddling doctor a dry labor, with all its dangers and protracted misery; moreover, the catheter may admit air into the uterine cavity with fatal result.

The freedom of the medical press is certainly going to seed when articles recommending such dangerous appliances are published in good journals without editorial criticism.

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#### THE HYDRIATIC TREATMENT OF TYPHOID FEVER.

In a little treatise upon this subject, Dr. Sihler (see column of Book Reviews) fully explains and strongly advocates the method of treatment by cooling baths and water compresses instituted by Brandt at Stettin, Germany, some thirty years ago. This method has not found favor in this country, although cold water has been and is still applied by very many physicians in a less heroic and systematic manner.

The purpose of Dr. Sihler is to induce the profession of America to adopt the method of Brandt in its entirety. The earnestness of the author's purpose is attested by his own adoption of it, in the face of popular prejudice and by his publication of his treatise at his own expense. On review of his work we have not been brought to acquiescence in the teachings inculcated by him without many mental reservations, yet the perusal has been profitable and we are glad to recommend the book to those who wish to know exactly what has been done in this department of therapeutics and what special and general results follow the treatment indicated.

The tendency of the day in the best hospitals in America and among the best private practitioners is, we believe, toward the view that water is the best agent for keeping down the temperature of typhoid fever, but whether it shall be hot or warm, or cool or cold, and in what range of temperature it is needed, are matters still in dispute.

Brandt's method seems to require the use of water baths at various temperatures below the fever heat of the patient (and consequently "cool" as far as the patient is concerned). He insists that this agent ought not to be employed as a remedy for the excessive fever of the middle and later stages of typhoid, but that it ought to be employed from the *very beginning of the fever*, and that its virtues are rather in the line of prevention of severe illness than of the cure of alarming conditions. Its merits cannot be fairly tested unless it is employed at least as early as the *third day* of the illness. Its benefits are manifested in three ways: first, it reduces the temperature; second, it acts as a tonic; third, it produces a revulsion of blood to the skin, and so relieves passive congestion of the internal organs.

In order to carry out the method, a bath-tub full of water should be brought to the bed-side, the patient (if necessary, after a dose of liquor) should step into it and immerse his body to the neck for fifteen minutes, while cool water is poured upon the head. The struggles of the patient and the coldness of the surface of the body and partial collapse, which accompany and follow the bath, should be disregarded. The patient, leaving the bath, should be helped into bed and be wrapped up—not too warmly—with a hot bottle to his feet; and cold compresses are applied. Great benefits are claimed to ensue if the baths be given early enough and frequently enough (about every four hours, day and night) to keep the temperature below 102°, and the discomfort and the mortality are said to have been thus marvellously reduced.

Dr. Sihler appends an account of some thirty cases treated by himself in this country according to Brandt's method, but his mortality has not been so strikingly small as Brandt's.

The reports of European physicians upon the subject are interesting to American practitioners as showing what has been done there, but as a guide in our own practice, Dr. Sihler's observations are much more valuable. The question for us is not how Europeans have borne the baths, but how our own people will bear them. The German and French statistics (except Brandt's) are largely from military hospitals, and we have no warrant for believing that our delicate private patients will react as well to the baths as the strong and hardy European soldiers. Brandt declares that his method cannot, for various reasons, be thoroughly tested in civil hospitals.

We are, therefore, shut in for our own guidance to experience learned from private patients in our own land. Such experience will necessarily be very slowly gained, and it is very doubtful whether the method of Brandt will ever be adopted, or even fairly tried, by our profession in America. Few private practitioners here will enter upon its employment with as firm confidence of its virtues as Dr. Sihler, and few will be willing to tell their patients, as he did, that they must either submit to the baths or get another doctor. Besides, the assertion that they do good in all sorts of febrile affections will hardly convince the public that they ought to be used (as Brandt and Sihler insist) even before

the diagnosis of typhoid fever is clear; and poor families will object at this stage to the extra labor in nursing and to the expense of a bath-tub, even though the physician urges that it is cheaper than a coffin.

The method of Brandt and its exposition by Sihler and others should, however, be carefully considered by every thoughtful practitioner, for there is something in it, and a proper mastering of its principles, and a judicious application of it in suitable cases, would probably save many patients who would be lost under any other method of treatment.

#### FEEES FOR REPORTING INFECTIOUS CASES.

The *Lancet* comments unfavorably on the "shabbiness" of certain sanitary authorities in Scotland in begrudging the fee of \$50 which was due to a practitioner for reporting infectious cases according to law. They were, however, compelled to pay it. The *Lancet* says: the authorities wish to have the benefit of the notification law. Why do they not then pay for it graciously?

If a journal of such high tone as the *Lancet* does not think it undignified for physicians in Great Britain to receive fees for such services to the community, is it not mistaken pride and foolish generosity which leads our American profession to do it for nothing?

#### Reviews, Books and Pamphlets.

*The Hydriatic Treatment of Typhoid Fever According to Brand, Tripier, Bouveret, and Vogl.* By CHR. SIHLER, M. D., Ph. D., Professor of Histology in the Medical Department, Western Reserve University. Formerly Fellow of the Johns Hopkins University and Assistant in the Biological Laboratory. A complete guide to the water treatment of typhoid fever. 340 pages, 12 mo., price \$1.50. C. Sihler, 832 Scranton Ave., Cleveland O.

The subject of this valuable work is discussed in the editorial columns of the present issue. The book is neatly bound in cloth. Its numerous typographical errors are to be pardoned on the ground that the author was compelled, for reasons stated in the preface, to undertake its publication himself. We cordially recommend the work to all who desire light upon the treatment of typhoid fever, that is, to every practitioner who is not already accurately acquainted with the method described.

We are asked to give this notice: E. B. Treat, Publisher, New York, has in press for early publication the 1892 *International Medical Annual*, being the tenth yearly issue of this deservedly popular work. Its corps of thirty-five editors are specialists in their respective departments, and have been carefully selected from the brightest and best American, English and French authors. It is the embodiment of what is worth preserving of the current medical journals of the world for the year, and will contain over 6,000 references to diseases and their remedies. The service rendered the profession by this Annual cannot be over-estimated, and it is an absolute necessity to every physician who would keep abreast with the continuous progress of practical medical knowledge. This Index of New Remedies and Dictionary of New Treatment, epitomized in one ready ref-

erence volume at the low price of \$2.75, make it a desirable investment for the busy practitioner, student and chemist.

J. B. Flint & Co., New York, have in press, and ready early in the current year the following books: A complete system of *Gynecology and Obstetrics*, with 869 new illustrations based upon translations from the French of Pozzi, Auvar and others, revised by CHAS. JEWETT, M. D. Bound in leather or half morocco, \$8.00.

Flint's Condensed Complete *Encyclopaedia of Medicine and Surgery*. Arranged upon a new system, and embodying the various methods of treatment employed by eminent practitioners. The most valuable and complete work of this nature ever published. The result of a year's labor of a large corps of writers. Leather or half morocco, two volumes, \$8.00 per volume. The above works sold by subscription.

Also in press, ready March 1st, the *Electro-Therapeutics of Gynecology*, by AUGUSTIN H. GOELET, M. D. Cloth bound, \$2.50.

*A Manual of Hypodermic Medication*. By ROBERT BARTHOLOW, A. M., M. D., LL. D., Emeritus Professor of Materia Medica, General Therapeutics and Hygiene in the Jefferson Medical College of Philadelphia, etc. Fifth edition, revised and enlarged. Philadelphia: J. B. Lippincott Co. 1891.

The medical profession is thoroughly familiar with former editions of this work. In the present issue many important alterations have been made and the entire book has been so recast as to have materially changed the scope and character of the work. These changes have increased the size of the book some 200 pages. The work in its present form presents a complete study of the subject of hypodermic medication, since it includes the entire list of agents used by this method. The volume has been prepared with the author's well-known care and skill, and is, without doubt, the most complete treatise upon this subject in print. It is a book of great value to the profession.

*Hand-Book of Materia Medica, Pharmacy, Therapeutics, etc.* By SAMUEL O. L. POTTER, A. M., M. D., M. R. C. P., Professor of the Theory and Practice of Medicine in the Cooper Medical College of San Francisco, etc. Third edition, revised. Philadelphia: P. Blackiston, Son & Co. 1891. Pp. 727.

Former editions of this work are familiar to students of the subject of which it treats. This, the third edition, has been thoroughly revised, and much of the text entirely re-written. Such new matter has been incorporated throughout the text as to bring the work up to the requirements of the present day.

### Medical Progress.

#### THE DISH-RAG GOURD AS A SUBSTITUTE FOR SPONGES.

In the *Texas Courier-Record of Medicine*, December, 1891, Dr. Beall writes;

As an agent for procuring asepsis before operations, I think nothing equals that commonly known as the Luffa dish-cloth or inside of the vegetable dish-rag gourd, which has many points to recommend it as superior to sponges, gauzes, cotton cloth, however prepared, and I desire to call the attention of your readers to some of the points worthy of consideration:

1. Cheapness—two or three uncultivated vines upon the yard or garden fence will be adequate to supply the ordinary requirements of a busy surgeon. They can be raised for the market at a cost insignificant as compared with the cost of sponges.

2. They will not irritate the skin.
3. It will bear any kind of antiseptic solutions or soaps.
4. It will remove dirt and infectious material quicker and surer than any agent known in nature.

Take a pan of hot water and soap, and experiment upon hands, neck, face, or scalp, and a presentable condition is soon brought about.

These vegetable rags can be readily removed from the shell when needed. I understand they can even now be procured in the markets of New York and Philadelphia, though not used by surgeons as a means for securing antiseptic (surface) conditions for operations. They can be found in many places in this and adjoining States. A paper of seed can be obtained from horticulturalists for five or ten cents.

Let me urge upon the profession to try these cheap agents for cleaning any surface upon which the knife is about to be used, and I confidently assert that whosoever does has never in life resorted to a more thorough and facile mode for inducing surface cleanliness.

#### MEDICAL MEN AS HEALTH INSPECTORS.

In an interview quoted by the *Pacific Med. Jour.*, December, 1891, Dr. McNutt, of San Francisco, declared that:

The Health Inspectors should be medical men. Nearly every medical college now has a chair of hygiene and every medical student receives instruction in the science of sanitation. A young physician as health inspector would be of incalculable benefit to a well organized health department. He should be requested to live in his district and to respond to all calls from the police. He should also act as public vaccinator for his district. This service would require no additional expense to the city, as a young physician would be glad to fill all the duties of the present Health Inspectors for the salaries paid them (\$100 per month).

I believe also that the Health Officer should be allowed an assistant, whose especial duty would be the inspection of public buildings, particularly schools. For instance, an inspection of the school on Geary Street near Jones would show that the underground or cellar department is a *bacterial incubator, that will generate more cases of consumption than all the Kochs in the world can cure.*

This reminds us of the recent resolution of the Clinical Society of Maryland upon the same subject. We doubt if San Francisco can present more unwholesome specimens of public school buildings than can be found in Baltimore.

#### GALVANISM IN INTESTINAL OCCLUSION.

Dr. Semmola states in regard to this subject that:

1. There may be an intestinal occlusion caused solely by a defect of innervation.
2. The curative effect of the constant current is, in such cases, very remarkable.

A case of obstinate constipation in a lady about fifty years of age, under the care of the writer, presented all the symptoms of intestinal occlusion. Large doses of active cathartics were given without success. Thirty grains of calomel at one dose brought no change. At the suggestion of the late Dr. Joseph C. Hutchison, who was called in consultation, a large dose of metallic mercury was given and massage employed in the hope of removing the obstruction, without effect. On the sixteenth day the interrupted or Faradic current was used; the negative, through an olive-shaped electrode, was applied within the rectum; the positive, over the abdomen. On the eighteenth day the obstruction was removed and a copious evacuation gave almost instant relief. The recovery was perfect.

For further details of Dr. Semmola's paper see article on "Intestinal Obstruction" in the *International Medical Annual* for 1890, p. 333.—*Sanitarian*.

#### A NEW ELECTRICAL CARRIAGE.

Electrically propelled vehicles are among the many conveniences which novelists and fiction writers have ascribed to future ages, while practical inventors have given their attention to subjects that bring them more satisfactory results, such as street car work. A departure from this line of thought is afforded in the electrical carriage invented by Wm. Morrison, of Des Moines, Ia. The motive power is obtained from 24 accumulator cells placed under the seats, while the motor itself is on the rear axle. The winding of the motor is so arranged that a reversal of the current will cause the carriage to run backward as easily as forward, while the steering apparatus is arranged simply and effectively.

This carriage has been in practical operation in the streets of Des Moines for some time, and will soon be seen in Chicago.

From the satisfactory results obtained from this mode of locomotion, the day does not seem so very far distant when carriages as well as other vehicles will be moving around our streets propelled by electric motors that receive their current from concealed batteries, and, therefore, effect a further emancipation of the millions of animals now performing this service.—*The Electrical World*.

#### Medical Items.

The Paris Society of Medicine offers a prize of 1,500 francs and a gold medal for the best essay on tuberculosis, to appear before the end of 1892.

The free use of pine-apple juice is recommended to dissolve the membrane of diphtheria. It is said to contain a vegetable pepsin analogous to papoid.

A large sum of money has been bequeathed to various hospitals of New York City by the late Mrs. Robert L. Stuart. The sums reach \$60,000 to \$80,000.

A physician in Paris found 32 out of 35 men employed in the Electric Lighting Works in Paris were suffering from tuberculosis, 23 of them having become infected since entering the shop.

A woman in New York State, thirty years old, married eight years, has given birth to fourteen children; viz., triplets three times, twins twice, single birth once. Only four children are now living.

Washington gossip has it that the former director of the Marine Hospital Service is tired of Chicago and wants his old place in Washington, but that his successor, the present incumbent, naturally wants to stay where he is.—*Med. Rec.*

From a report drawn up on the subject of cremation in France recently it appears that, although strictly forbidden by the Roman Catholic priests, the total number cremated during the year 1891 was about 150. In 1889 the number was only 49.

World's Fair committees have been appointed by the several societies to act conjointly with reference to medical matters, and some outcome is patiently awaited. A very busy and progressive man, Dr. Charles Warrington Earle, has the matter largely in hand, and will, no doubt, continue its vitality.—*Med. Rec.*

Mr. Rose, of King's College Hospital, recently removed the Gasserian ganglion from a woman, sixty-three years of age, who had for two years suffered from very

severe neuralgia of the supra and infra-maxillary divisions of the fifth nerve. The operation was successful, the patient being entirely relieved from pain. Mr. Rose has performed this operation now four times.

Professor Ernest William Brucke, the distinguished physiologist, is dead at Vienna. Professor Brucke was born in Berlin in 1819. He was the son of a painter, but soon turned his attention to physiology, which he studied at Berlin and Heidelberg. In 1848 he became Professor of Anatomy at the Academy of Fine Arts in Berlin, and was called to the chair of Physiology at Koernigsberg, whence he went to Vienna in the following year as Professor of Physiology and Microscopic Anatomy.

The College of Physicians of Philadelphia announces that 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 \$180, will be made on July 14, 1892. Essays intended for competition may be upon any subject in medicine, and must be received by the secretary of the college, Dr. Charles W. Dulles, on or before May 1, 1892. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the College.

At a recent meeting of the Berlin Medical Society, Dr. Paul Guttman, of the Mobait Hospital, recommended a new medicament called Salophen. It is a finely crystalline substance, easily soluble in ether and in alcohol, but not soluble in water. It consists of salicylic acid and acetylparamidophenol in almost equal parts. Six to eight grammes can be given daily without injury to the patient. In acute articular rheumatism it soon removes the pain and the swelling. Sometimes, however, it fails to produce these effects, and it does not protect against relapses. In chronic articular rheumatism also it may be tried with success. It has a slight antifebrile effect.

The International Executive Committee of the Pan-American Medical Congress, which meets in Washington, D. C., Sept., 1893, announces that the Committee on Organization of the Pan-American Medical Congress at its meeting at St. Louis last October, elected the following International Executive Committee: The Argentine Republic, Dr. Pedro Lagleyze, Buenos Ayres; Bolivia, Dr. Emelio Di Tomassi, La Paz; Brazil, Dr. Carlos Costa, Rio de Janeiro; British North America, Dr. James F. W. Ross, Toronto; British West Indies, Dr. James A. DeWolf, Port of Spain; Chili, Dr. Moises Amaral, Santiago; United States of Colombia, Dr. P. M. Ibanez, Bogota; Costa Rica, Dr. Samuel Nunez, San Jose; Ecuador, Dr. Ricardo Cucalon, Guayaquil; Guatemala, Dr. Jose Monteris, Guatemala Nueva; Hayti, Dr. D. Lamothe, Port au Prince; Spanish Honduras, Dr. George Bernhardt, Feguagalpo; Mexico, Dr. Tomas Noriega, City of Mexico; Nicaragua, Dr. J. I. Urtecho, Grenada; Peru, Dr. J. Cassmira Ulloa, Lima; Salvador, Dr. David J. Guzman, San Salvador; Spanish West Indies, Dr. Juan Santos Fernandez, Habana; United States, Dr. A. Vander Vier, Albany, N. Y.; Uruguay, Dr. Jacinto DeLeon, Montevideo; Venezuela, Dr. Elias Roderiguez, Caracas. Hawaii, Paraguay, San Domingo, the Danish, Dutch and French West Indies are not yet organized. Nominations of local officers have been received from a majority of all the members of the International Executive Committee, and a number of the lists have been confirmed by the Committee on Organization. These will be announced as rapidly as acceptances are received. Further information may be obtained from Charles A. L. Reed, M. D., Secretary General, Cincinnati, O.



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NO. 566

## CONTENTS

### ORIGINAL ARTICLES.

A Peculiar Accident During a Litholapaxy. By  
L. Bolton Bangs, M. D., New York. . . . . 287

Hæmoglobinuria. By David Streett, M. D., of  
Baltimore. . . . . 289

Trophic and Sensory Disturbances in Locomotor  
Ataxia. By Geo. J. Preston, M. D., Baltimore. 294

### EDITORIAL.

The "Circulation Element" in the Inception of  
Disease. . . . . 296

Stirpiculture. . . . . 297

REVIEWS, BOOKS AND PAMPHLETS. . . . . 288

### MEDICAL PROGRESS.

Causes of Lateral Curvature of the Spine.—Are  
Micro-Organisms Normally Present in the Tis-  
sues?—Water as a Local Anæsthetic; Its Dis-  
covery American and not German.—Coma and  
Drowsiness as the Only Signs of Epilepsy.—  
Onoma mania.—A New Treatment of Congen-  
ital Dislocation of the Hip-Joint.—The Diag-  
nosis of Pleural Effusion.—Pichi in Cystitis.—  
The Untoward Effects of Sulphonal. . . . . 299

MEDICAL ITEMS. . . . . 307

## Original Articles.

### A PECULIAR ACCIDENT DURING A LITHOLAPAXY.\*

BY L. BOLTON BANGS, M. D.,

Professor of Genito-Urinary and Venereal Diseases in the N. Y. Post-Graduate  
Medical School, Surgeon to St. Luke's and Charity Hospitals.

Accidents complicating the operation of litholapaxy have been reported from time to time, but they have been usually in relation to the urethra and bladder; or from the breaking of the lithotrite, or the clogging of the jaws of the instrument, or from difficulty in entering the evacuating tubes. But I have never read or heard of an accident whose mechanism was due to the stone itself, and therefore it seems to me that the narration of the following case may be of interest to you.

The patient was a man, aged 56, who came under my observation in December last. He was in general good health until six or seven years ago, when he began to have difficulty in starting the stream of urine and was compelled to empty his bladder frequently, passing considerable urine at each time. These symptoms have become progressively worse ever since that time. For three years past he has been obliged to use the catheter. Only within the past year has there been any pain in the bladder, but this pain has been very severe and paroxysmal, especially during the past few months, and was frequently referred to the glans penis. Sometimes his urine has been bloody. Recently, *i. e.*, just

\*Read at a meeting of the Section on Genito-Urinary Surgery of the New York Academy of Medicine, January 14, 1892.

before coming under my observation, he has passed some small crystalline calculi. His urine is alkaline, S. G. 1008, albumen about 6 per cent., sediment contains pus, triple phosphates, and a few blood cells. He passes in the 24 hours over 100 ounces of urine.

At my first examination of his bladder a stone was easily detected. There was not the slightest difficulty in entering the bladder. Indeed, it was a very simple procedure. There was no irritability of the urethra and no special pain was caused by the introduction of instruments. So far as could be determined by the searcher, the stone seemed to be of rather more than medium size. In view of the ease and simplicity of instrumentation, together with the fact that the man had chronic nephritis, it seemed wiser to me to remove the stone by the operation of litholapaxy than by any form of cystotomy.

On December 7th, the patient was put under ether and the usual preparatory steps for the operation were taken. The lithotrite was easily introduced and a stone one inch and a half in diameter was seized and crushed. The evacuating tube was also introduced in turn, and several fragments with some granular debris pumped out. Reintroduction of the lithotrite for further crushing was found to be impossible. Several attempts were made, but for some reason the instrument would not pass beyond a certain distance. With the finger in the rectum, the beak of the instrument was found to be apparently engaged in the prostate, but beyond that it would not pass. Considerable force—such force as I felt justified in making—was used and resisted, but the resistance seemed to be of an elastic kind. Nevertheless, I did not feel warranted to force or thrust the instrument forward to overcome this resistance of whatever kind it might be, lest damage should result to the surrounding tissues. Instruments of different kinds and with various curves were used, but all attempts met with the same result. They all seemed to reach the prostate and there were prevented from further passage. I persevered for several minutes (say, half hour) or until it seemed evident that nothing introduced by way of the urethra would overcome that resistance, and then decided to open the bladder, remove the stone and explore. Accordingly, a rapid suprapubic cystotomy was made with the usual technique. Not until my finger entered the bladder and searched it carefully did I appreciate the peculiar nature of the obstacle offered to instruments passed by way of the urethra. Nor could any explanation of the difficulty have been obtained without digital or ocular exploration of the viscus. It was found that a moderate amount of median hypertrophy of the prostate existed and a prolongation of the left lobe backward into the bladder, the urethra entering the bladder through this medio-lateral hypertrophy. The lateral projection was soft and flexible, and behind this, thrusting it forward toward the right, was the remaining large fragment of stone, caught between it and the posterior wall of the bladder. It had, after the first washing, fallen behind this prostatic obstruction in such a way as to close the internal orifice of the urethra and completely shut off access to the bladder by way of the urethra. The point of the instruments easily entered the prostatic urethra but immediately impinged upon this *dislocated* (so to speak) wing of the prostatic body which was firmly held by the fragment of stone behind it.

This condition of things would never have been appreciated but for the opening in the bladder and the associated explorations. It seems to me to be worthy of note because of its peculiarity and also because it may have some bearing upon a closer discrimination as to the choice of operation.

The subsequent history of the patient was uneventful. There was no compli-

cation during convalescence unless it be that the opening in the bladder was a little longer in healing because of the very large quantity of urine secreted by the kidneys.

31 E. 44th St.

### HÆMOGLOBINURIA.\*

BY DAVID STREETT, M. D., OF BALTIMORE.

Hæmoglobinuria is a pathological condition in which an essential feature is the presence of hæmoglobin in the renal excretion.

Being secondary to hæmoglobinæmia, it is not, *per se*, a disease, but one of the clinical phenomena occurring during the *progress of* a very obscure condition.

Hæmoglobinæmia, itself the effect of an occult process, is a step nearer the *primary* cause than hæmoglobinuria.

Nosologically, therefore, we know not in what category to place it; *convenience* suggests that for the present it be placed among diseases of those organs, the resulting perversion of whose function yields the most salient symptom by which it is recognized. So far as is known, the primary lesion is the vacation of the stroma of the red blood corpuscle by its component, hæmoglobin.

The latter is composed of hæmatin, a substance containing iron, and a colorless, proteid body, closely allied to, or identical with, globulin. In the blood, in this disease, are found phantom cells or shadows of cells—the colorless bodies of red blood corpuscles devoid of hæmoglobin. The blood, therefore, contains, dissolved in its serum, free hæmoglobin, rendering it brighter red than normal blood serum.

The kidneys are normal in size, or somewhat enlarged, and occasionally inflamed.

Ponfick, Lebedeff, Litten and Lassar believe that nephritis, though *secondary*, is *invariably* present. The convoluted and straight tubules are filled with plugs of hæmoglobin, a reddish, fine, granular, or amorphous powder.

Some of the epithelium of the tubules is affected by cloudy swelling of the cell protoplasm, and some of the cells are detached subsequently to their degeneration. Dr. Bridges Adams has shown that hæmoglobin is found within Bowman's capsule, a fact of *much importance*, indicating that hæmoglobin is eliminated within the *capsule directly* from the glomeruli, and *subsequently* passes down into the tubes; and that it is *not excreted* by the glandular epithelium. The degeneration of the latter is, therefore, probably due to interference with their *nutrition by pressure* of plugs of hæmoglobin, or by reason of its *presence only*.

Examination of the blood during a paroxysm shows the presence of microcytes and poikilocytes. The kidneys are of a dark chocolate color, and on section present a brownish, striated appearance.

Hæmoglobin is also deposited in the spleen, which is usually of normal size, or somewhat enlarged and pigmented. It is likewise deposited within the liver and marrow of bones. Hoffman describes a case in which the medulla of the upper half of the femur was of a dark brown color. The skin is icterotic from deposition of hæmatin in its structure.

Ecchymoses have been observed in the mucous membrane of the stomach and intestines. Mild attacks of hæmoglobinuria are inaugurated by *correspondingly* mild symptoms, such as slight headache, thirst, gaping or yawning, malaise and

\*Read at the 734th meeting of the Medical and Surgical Society of Baltimore, Jan., 14th, 1892.

debility, and followed by voiding renal excretions, having a dark or chocolate brown appearance. In a few hours the symptoms have disappeared and the fluid excreted by the kidneys is normal or pale in appearance, and the invalid is as well as usual except the slight languor and debility which succeeds the attack.

In cases of *average* or *greater* severity, the attacks are sudden, and ushered in by a chill or chilly sensations, with gaping, nausea, great physical depression, general malaise, pain in head and limbs, and thirst. This is followed by rise of temperature to 101°F. or 103°F., increased cephalalgia, thirst and vomiting. Some cases at this period have subnormal temperature and a pulse less frequent than the normal, with skin cold and cyanosis in cheeks, nose and lips.

In those cases with rise of temperature and frequent pulse—110 to 120 per minute—this condition is maintained for several days, and then followed by great physical depression, with ashy pale lips and skin covered with cold clammy perspiration, characteristic of the cases marked by profound depression during the first stage. In cases with cold skin, there is usually a pale or dusky color of the hands and feet, as well as of the lips, ears and nose. This cyanosis may continue for several days and the circulation may not be re-established in ears, parts of which have been known to slough. The condition at *this* time approaches that of collapse. Jaundice ensues, beginning to appear in about 24 or 48 hours after commencement of the attack; the yellowish discoloration of skin and sclerotic becoming marked. The nausea, which begins with the advent of the disease, is *distressing*, culminating in *vomiting* and *continuous gastric tenesmus*. Tenderness on pressure may be marked over the epigastrium; in cases with *this* condition it is presumable that gastro-enteritis, either *primary* or *secondary*, is present, the result of which would be, in some cases, to supplement the icteroid condition of skin and other tissues with hepatic jaundice. Though thirst is *prominent* appetite is very *indifferent*, and may be absent. The alvine evacuations are usually frequent, but the opposite may prevail. Pain in back and limbs is very *pronounced* and *headache* is sometimes *very distressing*. Pain may be marked over hepatic area. Cases due to the malarial organism have severe paroxysms, and are liable to recur until arrested by quinia or other appropriate medication.

Urticaria may contribute to the general discomfort. The attacks may recur several times per day or week. Dysuria may be present, indicating either *cystic* or *reflex renal* irritation.

The renal excretion has a sanguinolent appearance, and stains white surfaces *similarly* to blood. It is of a dark red, chocolate, or purple color, *acid* in reaction, has a specific gravity ranging from 1005 to 1015, and upon testing with heat and nitric acid yields a coagulum, *smoky* in color and floating on *top* of liquid in test tube, instead of *precipitating*, as serum-albumen *usually* does. This is *presumably* the *globulin* of the *hæmoglobin*, which was dissolved in the blood *serum* and is *now* eliminated by the kidneys. Microscopical examination reveals the presence of hyaline casts, some of which have adherent, reddish granules, and casts of the same reddish material, a few detached and degenerated cells of the tubules, and a *field covered* with a fine, reddish, amorphous material. Blood cells are *conspicuously* absent; *occasionally*, but *rarely*, phantom cells are seen. Iron is also revealed in urine by chemical examination.

Crystals of oxalate of calcium are sometimes present, and, *rarely*, crystals of hæmoglobin.

Dr. Druit, writing in *Medical Times and Gazette* in 1873, describes the attack of hæmoglobinuria, as occurring in himself, as causing wet and cold sensations, with cramps, bluish color in palms and soles, a clammy and cold choleraic feeling,

with numbness in right foot and left hand, and nose pale, red, or dark purple. His pulse fell to 55 per minute before the paroxysms. In severe cases the condition of patient may remain critical for three or four days, with pulse of 116 or 120 per minute, nausea and jaundice. *Reaction* sets in, and *convalescence* is rapid, the renal excretion becoming pale, free of albumen, and of low specific gravity. Well marked anæmia follows, and may remain for *weeks*, and in *chronic* cases, for *years*.

As presented in *practice*, hæmoglobinuria is generally due to the action of cold. Those predisposed to it experience attacks after exposure to *cold* in a *humid* atmosphere, more frequently than in a dry one. Getting the feet or body wet, or sitting in wet garments, will frequently develop a paroxysm. Some have it by simply dipping hands or feet in cold water. Some of those so predisposed experience an attack after exposure to slight draught, or after slight exposure before, or soon after breakfast, when the body is less able to resist any extraneous influences. These cases may be prevented by avoiding contact with cold air until *digestion* is *complete*. It occurs more frequently in fall, winter and spring than in summer.

Ehrlich, in 1881, demonstrated the potency of cold in exciting paroxysms of this disease by applying elastic ligatures near the end of finger, then dipping finger in iced water for fifteen minutes and subsequently holding it in tepid water for an equal time. Examination of blood drawn from the end of finger showed microcytes, poikilocytes and phantom cells. *Intense* cold will also cause it, as in frost-bite. The opposite extreme, *high* temperature, has *same* effect, particularly where a large surface of the body is burned, and after sun-stroke. Anxiety, worry, late study and little sleep, are set down as causes.

It may *accompany* or *follow any* of the infectious diseases, as malaria, typhoid fever (rarely), diphtheria, scarlatina, and syphilis. Occurring during the progress of diphtheria, it is probably due in most cases to the administration of *large* doses of chlorate of potash, it being *conceded* that *this* substance causes *more* cases than *all other* medicinal remedies combined. Among other substances causing it, when taken internally, are carbolic acid, creosote, naphthol, pyrogallic acid, nitro-benzol, arseniuretted hydrogen, sulphuric acid, hydrochloric acid, glycerine and even distilled water, when administered hypodermically. In case of primary hepatic jaundice the absorption of biliary salts causes it.

Eitner reports four cases, embracing a professor and three of his pupils, who suffered from an attack caused by repeating Tyndall's experiment of inhaling hydrogen gas, for the purpose of showing that the *pitch* of the *voice* is altered by it. The professor suffered several repetitions of the attack before discovering its cause, which he found to be arseniuretted hydrogen; the zinc used in generating the hydrogen was impregnated with arsenic.

The edible mushroom, *helvella esculenta*, contains a substance which causes the disease in a severe form.

*Violent* or *prolonged* physical exertion, and in some cases even *moderate* muscular exercise, excites an attack. It is occasionally caused by the gentle action required in making the morning toilet. In these cases it can be prevented by drinking hot coffee or broth before rising. It occurs in males more frequently than females; probably *not* because of the greater proportion of hæmoglobin in the blood of the former, but of the greater *exposure* of *former* to *causes producing* it. It occurs in young adults, and *generally* before 50 years of age. *Purpura* may predispose to it. Morning seems to favor the attack, possibly because it is *often* caused by cold, and in the morning the temperature of the body is lowest.

Winckel, in 1879, reported a remarkable outbreak in the Maternite in Dresden, where, between March 20th and April 29th, 24 infants were attacked by it, of whom 23 died. These cases were similar; the infants on fourth day after birth became cyanosed, collapsed and died. The excretion of the kidneys contained hæmoglobin, and sections of them showed tubuli plugged by masses of hæmoglobin. The general sanitary condition of the hospital at the time was good.

The malarial organism causes many cases, many having the disease giving histories of suffering from attacks of malarial fever *months* or *years* before.

Tyson states that *all* cases not due to the *hæmorrhagic* diathesis are caused by malaria.

The *primary* changes occurring in the disease are occult. By *whatever* caused, the hæmoglobin of the red blood corpuscle is *caused* to *vacate* its stroma, and becomes *dissolved* in the blood serum; the stroma *continuing* to circulate for a time as a phantom shell or shadow of a corpuscle.

Hæmoglobin is composed of hæmatin, a substance containing iron, and a proteid substance analogous to, or identical with, globulin. The latter is dissolved by the blood, and *consequently* eliminated by the kidneys in the form of *albumen* and *coloring* matter. The coloring matter is deposited in skin, kidneys and liver; in the skin causing jaundice; in the kidneys obstructing the tubuli, deranging the function of the renal epithelium, and impairing the utility of the kidneys as excretory organs. It is *similar* to the bile pigment.

Hæmoglobin is eliminated as oxyhæmoglobin or methhæmoglobin, a more stable compound, as shown by spectroscopic analysis.

Hæmoglobinuria is *secondary* to hæmoglobinæmia. It is presumed that the malarial organism causes the disease by directly attacking the red blood corpuscle. Heat and its negative, cold, cause it, by compelling the hæmoglobin to withdraw from the red blood corpuscle, either by *direct* influence, or by some unknown influence, through the nervous system; either *primarily* on cells, or by production of *abnormal* metabolism, generating in the blood substances inimical to the hæmoglobin of the red blood corpuscles.

These *exciting* causes but determine the *date* of attack, in one *predisposed* to the disease.

Headache, stupor, and often the nausea, are due to the development of uræmia. The renal secretion is of low specific gravity, contains albumen, casts, little solid matter, a few detached epithelial cells of tubules, and reddish amorphous material.

The general venous system is free of hæmoglobin, when the *primary* blood lesion is in the portal circulation. Those predisposed may *not* have it perceptibly when exposed to slight degree of cold; the small quantity of hæmoglobin, liberated in such cases, passing off as mild albuminuria, devoid of any noticeable discoloration. Once set free in the blood, hæmoglobin is split up into hæmatin and globulin; the hæmatin becoming deposited as bile pigment, and the globulin eliminated as albumen.

In *essential* icterus, resulting from gastro-duodenitis, or obstructed bile duct in hepatic colic, it is claimed that the biliary salts being absorbed, cause solution of the hæmoglobin and hæmoglobinuria.

The diagnosis is made by clinical history of chill, nausea, vomiting, malaise, headache, jaundice, history of exposure to cold, to malarial infection, to attack of some acute infectious disease or syphilis, and of attack of hepatic jaundice; of its development most frequently in winter, spring and autumn, and rarely in

summer; more frequently in males; history of its following an extensive burn; or of developing in one weighed down with anxiety and business cares, or having to engage in some muscular exertion; and lastly, by examination of the renal excretion, which is found *usually* acid in *reaction*, of *low* specific gravity, *sanguinolent* in appearance, and on chemical examination with heat and nitric acid, yields albumen, which floats as a smoky coagulum at top of test tube, instead of precipitating like serum-albumen.

Microscopical examination fails to discover red corpuscles; shadows of corpuscle or phantom cells may be found; hyaline casts are usually present, as well as casts of a granular substance, and abundant reddish amorphous material scattered over field. Crystals of hæmoglobin may be found by placing on slide a drop of the liquid in question, saturating the same with small crystals of chloride of sodium, and then with glacial acetic acid, evaporating over a gentle heat and examining with microscope.

Exclude the abnormal color due to administration of santonin, logwood, rhubarb, carbolic acid, and creosote.

The mildest cases recover in a few hours, the kidneys at end of this time resuming their normal function. Cases of moderate severity recover in two or three days, leaving the invalid in an anæmic and languid condition. The gravity in severe cases depends upon the cause, the degree of hæmoglobinuria, the loss of albumen and emesis; added to this is the *primary* cause, continuing to act until removed.

Nephritis may develop, but usually disappears rapidly, when the hæmoglobinuria disappears.

The disease may recur at *short* intervals, *long* intervals or never. It may become chronic and paroxysms may occur frequently, the invalid becoming profoundly anæmic.

Dr. Stephen Mackenzie reported a case which lasted for 23 years.

In treating the disease, the primary object is to maintain the normal temperature and support the enfeebled circulation.

This is best accomplished by placing patients in bed and surrounding them with bags or bottles of hot water, hot bricks, etc., and giving hot drinks, covering well with blankets. If prostration be marked, carbonate of ammonia and brandy may be administered.

Nausea and emesis may be controlled by the usual remedies—creosote and lime water, subnitrate of bismuth, morphia sulphate, and counter irritation over epigastrium.

Ergot benefits by lessening the renal circulation, and the rapidity with which hæmoglobin is brought to the kidneys for elimination. The hæmoglobin, being thus gradually filtered out, is less liable to obstruct the renal tubuli, cause irritation, or nephritis. Bicarbonate of potash, grs. x, in glass of sweetened water every four hours is a good diuretic in these cases. Stimulating diuretics are contra-indicated. The best of all diuretics here, as in many other diseases of the kidneys, is abundance of water. Lithia water conveys benefits by lessening the irritation of the urates.

It the attack be due to the malarial organism, quinia should be given in doses sufficient to arrest it, and prevent the development of other paroxysms.

If indicated, aperients should be used. If a specific history be obtained, mercury and the iodide of potash should be given.

During convalescence, the ferruginous tonics are especially indicated; mineral waters containing iron or alum, or both, act kindly. In those evincing a

marked predisposition to the disease, from light and trivial causes, a paroxysm may be obviated by dressing with warm woolen underwear, and avoiding exposure to cold or draughts; by abstaining from violent exercise, or, in some cases, even from slight exercise before eating breakfast; by residence in a warm climate; by removing out of the malarial districts; and by opportunely counteracting, and if possible, removing any known cause.

### TROPHIC AND SENSORY DISTURBANCES IN LOCOMOTOR ATAXIA.†

BY GEORGE J. PRESTON, M. D., BALTIMORE.

Gentlemen:—From our study of the physiology of the nervous system we have seen what an important part it plays in the nutrition of the body. Just how this function is performed, through what agencies, and in what manner, is not perfectly clear. We know from experiment, and we have seen a number of illustrative cases in this clinic during the winter, that when the large cells in the anterior horns of the spinal cord are diseased or destroyed, we have a rapid wasting of the muscles. From this we conclude that so far as the muscles are concerned, the cells of the anterior horns furnish and the motor nerves conduct the trophic influence. In locomotor ataxia we rarely have any marked muscular atrophy, and when it does take place it is due to the sclerosis invading the gray matter. The trophic disturbances that occur in this disease are herpes, loss of hair, loss of pigment, falling out of the teeth, a peculiar ulceration known as perforating ulcer, together with other limited ulcerations, vasomotor disturbances, and especially changes in the joints. You will recall, perhaps, a case of perforating ulcer of the foot which I presented to you not long ago. The two cases I show you to-day present some very interesting trophic symptoms. The first case shows, as you see, a marked deformity of the knee joint. The ataxia is of some years' standing, but a few months ago the patient was able to walk quite well, and now, as you see, he is disabled entirely on account of the disease of his knee. The history he gives is that his leg suddenly swelled up from no apparent cause, and without any special pain. A day or two after the swelling he tried to walk and felt something give way. As you see, the joint is very much enlarged, and there have been marked changes in the bones. I can feel pieces of loose bone, and there is a large amount of callus formed. This form of trophic disturbance was first clearly described by Charcot and bears his name. It is characterized by its sudden onset, sometimes a few days, at others a few weeks. In our patient the joint seems to have been more or less destroyed in two or three days. The affection is attended with little or no pain, sometimes with, sometimes without œdema of the leg, and no fever. The bones are often dislocated or fracture takes place on slight movement. Often the articular surfaces are absorbed, leaving the capsule filled with loose pieces of bone. If the patient walks on the leg with assistance, as our patient has done by means of a brace, callus in large amounts develops as you see here. The knee joint is most commonly affected, but the elbow, ankle or hip joint may be involved. The other patient gives a history of a more or less painless whitlow, or what looks like a whitlow. You see the end of the third finger is nearly ulcerated off. I have not examined the bone carefully, though in all probability it is affected. There is a scar on the thumb of the same hand which looks like an old whitlow. While we cannot say with the same certainty as in

†A Clinical Lecture Delivered at the College of Physicians and Surgeons, of Baltimore, Jan. 19, 1892.



the first case that this is a trophic lesion, still it is probable. The ataxia, as you see, is very pronounced. This case is interesting in view of the discussion which is being carried on at present regarding Morvan's disease, which is characterized by painless whitlows. It is questioned by certain neurologists whether it is a distinct affection or merely a symptom of certain other diseases, especially syringomyelia.

There is another very interesting symptom of locomotor ataxia which is marked in both these patients, namely, delayed sensation to pain. When I stick this man with a pin anywhere below the knee, especially he says he feels the touch but does not feel the pain until after I have drawn my hand away. Upon timing it I find that there is a difference of from one to two seconds or more between the perception of tactile and painful sensations. There seems to be no delay in the perception of tactile sensation, but the conduction of painful sensation is markedly delayed. There is no delay or failure of appreciation of temperature sense. In the second case this symptom of delay in the conduction of painful impression is still more marked. He has more anæsthesia than the first case, so we cannot compare the two senses, but when I stick a pin in his leg you see he does not feel the pain for three, four or five seconds. An interesting point in his case is that while there is marked anæsthesia, he can readily perceive the difference between very moderately warm and cold objects, and there is no delay in the conduction of temperature sensations. From these experiments we conclude that either there must be separate nerves for the conduction of tactile, painful and temperature sensations, or that the same fibre conducts these various impulses with different degrees of readiness. It seems to me probable, having in mind Goldscheider's temperature nerve experiment, that each sense may have a special set of fibres. Both these patients have a loss of muscular sense, which was spoken of at the last lecture. Knowing as we do the pathological anatomy of locomotor ataxia, it is fairly reasonable to conclude that the trophic disturbance is due primarily to disease in the conducting path of sensory impulses. The anterior cervical cells are never or rarely ever diseased in tabes nor are the motor nerves affected, hence we are forced to conclude that the trophic influences to the joints and skin especially proceed by the sensory tract in the cord and thence by the sensory nerves.

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The Illinois State Board of Health has provided that a year of study with a preceptor may be accepted as one year on a four year's course. This is usually taken before entering upon the college work proper, and most frequently this has been decidedly unsatisfactory. The College of Physicians and Surgeons of Chicago announce that this year it proposes to co-operate with the preceptors in laying out a course of reading and study. This course may be taken at the college or at home, but in case the non-resident course be taken it will be necessary to select a preceptor satisfactory to the secretary; satisfactory reports of progress must be made weekly to the faculty. The course covers thirty weeks and if five be unsatisfactory the student is debarred from credit for the course. When students have completed the work they will receive certificates from the secretary and these will be accepted in lieu of one year's study on a four years' course. The expense for matriculation, books and postage will be \$14.30. Biology, physics and Latin are the subjects which will be taken up this year. While the scheme is but an experiment as yet, still we believe that it has the elements of success in it. Any further information concerning the matter may be obtained from Dr. Bayard Holmes, the secretary.

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BALTIMORE, JANUARY 30, 1892.

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**Editorial.**

**THE "CIRCULATION ELEMENT" IN THE INCEPTION  
OF DISEASE.**

As we advance in years of practice in medicine, and become better acquainted with therapeutics, we are more and more impressed with the influence which inequalities in the force and distribution of the blood supply seem to exert in the production of many of the symptoms with which we have to deal and even in the original causation of the disease itself.

The peril which accompanies the sudden recession of the blood from the surface to the great internal organs in febrile affections which were pursuing a favorable course, are too well-known to require comment. With what joy does the physician watch the return of active surface circulation in such a patient as the consequence of his earnest solicitation by means of hot drinks, stimulants and hot fomentations. In these cases inequality in blood distribution and abnormal damming up of the blood in important inward organs appears to initiate the alarming symptoms.

Many local disorders are either due to, or associated with, disturbances of the circulation in limited districts of the body. They sometimes originate in a sudden cooling of the surface, and are sometimes dependent reflexly on disturbances of distant organs. In both cases abnormal fullness, or a deficiency of the blood supply, in the part, appears to be the immediate cause of the symptoms. The facial neuralgias and scalp-aches of sensitive women are evidently of such causation. The practitioner who best understands the agents by which the circulation in a part of the body may be equalized or corrected, will most quickly cure such troubles. Physicians of merit often receive reproach, especially from the fair sex, because they have never thought it worth while to familiarize themselves with the therapeutics of local circulatory disturbances. The liniment, the blister, the dry-cup, the poultice, the local cold pack, the electric current,

massage, all seem to produce their benign effects by equalizing the local blood supply, correcting its excess or deficiency, or rendering its flow more natural.

In certain affections we may observe with the eye the local disturbances of internal parts, which underlie the more evident symptoms. Thus, in pharyngitis, laryngitis and otitis, the cause of the illness is manifest. And here it is that circulation controllers, such as belladonna, aconite and digitalis, are reported to work wonders in the hands of him who understands the circulatory condition in which each is indicated.

But it is to the circulatory disturbances of organs which lie quite out of sight that we would now especially direct our thoughts. To what extent do the general febrile diseases arise in and proceed from circulatory disturbances of the great hidden organs? Were our fathers right in believing that pneumonitis, for instance, could be aborted by that most powerful of all circulation controllers—blood-letting—under whose influence the hard and irritated pulse became soft and calm; the struggling lungs found relief; the intestinal secretions were unlocked; the burning skin was cooled by refreshing perspiration; and the fevered, pain-wrenched patient sank into peaceful, restful slumber? How often have we seen the little child recover from what was, as far as could be seen, the beginning of a grave febrile disorder, after a "good clearing out of the bowels" by a dose of salts or calomel or oil. What was this but the relief of some abnormal condition of the circulation in the great organs of digestion? No need of anodynes for the pain, or of antipyretics for the fever. He who knows the rapidity with which the vigorous, uncrippled system of the little child reacts in every function when the digestive organs are relieved from their oppressive burden of sluggish blood, has recourse at once to an aperient.

The most recent developments of the "germ-theory" seem to teach that the body, with a vigorous, healthy circulation in its every part, may bid defiance to almost any invading disease agent; that even when deprived of its protecting epidermis or epithelium it will make a noble and probably a victorious fight; but that a part with sluggish or deficient circulation is a ready victim to any injurious organism.

It is the duty, then, of the physician to be ever on his guard against serious disturbances of circulation, and to encourage his patients to consult him in the very beginning of disease, when the local disturbance may be readily relieved and dangerous illness prevented. This injunction, which has always been respected by intelligent physicians and patients, has now been rendered all the more commendable by the light which science has thrown upon the manner of entrance of disease agents into the human body.

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#### STIRPICULTURE.

Among certain persons of culture there seems to be a tendency to the belief that mankind might be uplifted physically, intellectually and morally, if only

a proper effort were made to apply the teachings of science to the propagation of the human race.

Unfortunately for their theories, history records the failure of an effort in this direction, which, if we may believe Mr. McGee (writing in the *Herald of Health*, January, 1892), was most honestly and scientifically carried through to its conclusion. We refer to the famous "Oneida Community," of New York State.

As described by our author, whose article is well worthy of perusal, this community was the outcome, not of unbridled lust, but of the philosophical reasoning of a cultured and intellectual man; who by his ethical teachings drew about him a circle of followers, and who attempted to perpetuate his society and secure its continuous advance in virtue of every form by the application of the scientific principles of breeding, which have heretofore been applied in the rearing of blooded stock, or have been suggested by the the observation of race-development in man.

The experiment was a grand success as far as the physical sphere was concerned. Death in infancy was greatly lessened, and sickness in the community was rare. We may suppose that the children were of fair intellectual and moral character, as they afterwards assumed respectable positions in society. From the religious point of view it did not produce the results sought, for the tenets of the parents were in almost every case rejected or neglected by the children.

It is very interesting to observe that the community, after twenty years of existence, came to its end through the development among its members of a steadily increasing desire for ordinary marriage;—a powerful argument in favor of the belief that the union of one man to one woman for life is the original and normal form of marriage.

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### Reviews, Books and Pamphlets.

*Practical Pathology and Morbid Histology.* By HENEAGE GIBBES, M. D., Professor of Pathology in the University of Michigan, etc. Illustrated. Lea Brothers & Co. Philadelphia: 1891. Pp. 313.

The author of this volume is well-known for his work in this branch of scientific study. In the treatise before us he has presented such essential points as will familiarize the student with the work of a pathological laboratory. Such instructions are given as will enable him to transfer a specimen of any morbid change directly to his microscope in an unaltered condition and to recognize it unerringly. In the section on Practical Bacteriology the student is taught how to study with the microscope the different forms of micro-organisms in their growth, their action in animals by inoculation, and their morphology. All the formulæ and directions are given for the use of photography with the microscope. The work is written in a clear and practical style and will be found a most useful guide to the student and practitioner.

*The Urine, the Common Poisons, and the Milk; Memoranda, Chemical and Microscopical, for Laboratory use.* By J. W. HOLLAND, M. D. Professor of Chem-

istry and Toxicology, Jefferson Medical College, Philadelphia. Illustrated. Fourth edition; revised and enlarged. Philadelphia. P. Blackiston, Son & Co. 1891.

This book is intended to be used as a syllabus for the laboratory. Pages are left blank for calculations, memoranda or more extended notes to be made by the student. It will be found very useful as a work of reference in the physician's library.

*Mouth-Breathing not the Cause of Contracted Jaws and High Vaults.* By EUGENE S. TALBOT, M. D., D. D. S., Chicago. Professor of Dental Surgery, Woman's Medical College, and Lecturer on Dental Pathology and Surgery, Rush Medical College. Read before the American Dental Association, Saratoga Springs, N. Y., Aug. 4, 1891. Reprinted from *Dental Cosmos*, for Nov., 1891.

*Scope of Orthopedics; The Forms of Club-Foot, Tenotomy, the Etiology of Club-Foot, the Treatment of Club-Foot, the Plaster-of-Paris Bandage.* By H. AUGUSTUS WILSON, M. D. Lectures reprinted from *Medical and Surgical Reporter*, Dec. 5 and 12, 1891. Philadelphia. Binder & Kelly, 518-520 Minor St.

*Considerations upon Medical Hæmorrhage Surgically Treated, with a Successful Case, by a New Technique of Saline Infusion for Severe Hæmorrhage.* By ROBERT H. M. DAWBARN, M. D., Professor of Operative Surgery and Surgical Anatomy, New York Polyclinic.

*Annual Report of the Board of Managers of the Maryland Hospital for the insane, near Catonsville, Baltimore County, Md., Nov. 1891.* By GEORGE H. ROHE, M. D., Medical Superintendent.

### Medical Progress.

#### CAUSES OF LATERAL CURVATURE OF THE SPINE.

From the *American Lancet* we learn that at a recent meeting of the New York Academy of Medicine Dr. Scudder, of Boston, presented the result of an investigation into the seating of 3,500 school girls, with especial reference to the effect of poor seating upon spinal deformity.

Lateral curvature of the spine is in all probability due to several factors: (1), the superincumbent weight of the body falling upon a (2), spine weakened either in bone, muscle, or ligament, and (3), held persistently out of the median antero-posterior plane of the body.

He had made a careful examination of the seating in schools, and found that faulty positions, one of the elements of the third ætiological factor, are certainly induced because of the lack of adaptation of seat to pupil and pupil to seat. How much of a factor in causing lateral curvature poor seating is, it is impossible to say, but that it plays an important part there can no longer be any doubt.

The author suggested that the present seating arrangements of schools be used to better purpose than hitherto, by arranging scholars more carefully in the room and having careful supervision exercised by those in charge.

He then described the development of the adoption in the Boston public schools of the Swedish gymnastic system, and regarded it as of the highest importance as a measure likely to be somewhat preventive of spinal curvature induced by poor attitudes in sitting. This is to be brought about by no specialized gymnastics, but by general neutral movements which shall tend to develop the whole child along the lines of his natural muscular development.

Dr. Sayre said that if proper attention were paid to the physical training of girls, there would be few cases of lateral curvature.

Dr. Gibney said that the paper reminded him of some observations he had made at one time in our public schools. In passing through the schools he had been struck with frequent changes of position of the pupils, and had concluded that faulty attitudes were not so potent a factor in this condition as he had previously imagined. He was, however, willing to admit that it was quite possible that weak children, having once assumed a comfortable attitude, would be likely to maintain it long enough to be injured thereby.

Dr. Guiteras agreed with the author as to the great importance of the Swedish gymnastics in the training of the bodies of young children. As to the matter of desks, he was happy to say that school desks and chairs had recently been invented, which could readily be adapted to any height.

Dr. Taylor thought the author had shown indisputably the necessity for competent medical supervision of our public schools. As lateral curvature occurs rather more frequently among children of the well-to-do class, who, as a rule, attend private schools, where the seating of the children usually receives more careful consideration than in the public schools, and as this deformity also sometimes develops among children who have been entirely educated at home, he was not willing to admit that faulty school attitudes were very potent in producing the deformity in question. They undoubtedly do children harm, but it is still an open question as to how much they have to do with the production of lateral curvature. The instinct of young children is to keep in motion, and one of the great faults in our system of education is the absence of frequent short recesses. A recess of five minutes between each recitation, especially if utilized for gymnastic exercises, would prove very beneficial, and he hoped the paper would receive that wide and thoughtful attention which would lead to the introduction of rational physical culture into our school life.

The chairman said that his own impression was that no habit in itself, no matter how long continued, could produce an idiopathic rotary lateral curvature of the spine. Some years ago he had written upon the ætiology of this condition, especially in young children, and called attention then to the fact that the curvature was present before the children assumed these faulty positions—or, in other words, that the position was the result of the curvature, and not the cause. He was willing to admit, however, that a *curve* of the spine could be produced by a long continued bad position.

Dr. Scudder, in closing the discussion, said he recognized that, among the many factors which entered into the causation of lateral curvature, three important ones were, the superincumbent weight of the body upon the spine, 1, weakened by a diseased condition of the bone, *e. g.*, rickets; 2, weakness of the muscles (not yet demonstrated) and 3, weakness of ligaments. Although it was not yet known whether one or all are present in any given case, it was known that the superincumbent weight of the body falling upon a spine which is kept in a median plane of the body causes only an antero-posterior curve. This was known both by demonstrations on the cadaver and by observation on the living subject. But when the spine deviates from this median plane, a certain amount of lateral curvature results. His paper embodied a study of the effect of faulty positions on the body, and did not assert that faulty positions in themselves caused lateral curvature.

#### ARE MICRO-ORGANISMS NORMALLY PRESENT IN THE TISSUES?

In an article upon "recent biological researches in the field of medicine," Dr. Woodhead (*Lancet*, January 9, 1892), says:

It has recently been maintained that micro-organisms are present in all the tissues of the body, and that if a healthy animal be killed these micro-organisms will develop, multiply, and set up decomposition of the tissues in which they are present. Mr. Lawson Tait says, "A solid mass of beef—say, a bed and silverside—is removed from a perfectly healthy ox, and is put at once into a sound and healthy pickle. The pickle is a powerful antiseptic, and if the pickle reaches the middle of that beef before the germs contained in it have had time to start their work the beef in a few days or a week or two will be fit to eat; but every house-keeper knows perfectly well that the result will depend absolutely upon the outside temperature. It would be absolutely impossible to pickle a piece of beef in August which could be easily pickled at Christmas." And then he goes on to argue that during the few hours, or maybe few minutes, that the beef is exposed to the air it does not become impregnated with germs right to the centre; but that it is more consistent with common sense to believe that the germs were in it before it left the ox, and therefore in life. I have in connection with this matter experimented most carefully with a view of determining whether in a healthy animal micro-organisms really find their way, or remain for any length of time capable of development and multiplication in the animal tissues. I have repeated the experiments made by Chiene and Ewart, Burdon Sanderson, Ballance and Shattock, and others, and I am convinced that in a healthy animal or in a healthy human being there are no organisms to be found, except in certain cavities of the body directly continuous with the external world; and that, even in some of these cavities and passages, as Lister long ago pointed out, where the walls are in close apposition, micro-organisms cannot exist. In the urethra, for example, no organisms are found beyond the meatus urinarius externus until the patient dies. If, however, the blood of an exhausted animal, or of a patient who has just died from some disease, be examined, or if particles of the dead tissues of diseased animals be examined in the same way as tissues of the healthy animal were examined, organisms may undoubtedly be found. We must therefore assume that in these instances the barriers which under ordinary circumstances exist have been broken down, and the micro-organisms have made their way from the respiratory passage or from the alimentary canal into the circulation, and so to the weakened tissues by which they are not immediately killed off. This is a point of very great importance, for we know that in cases of pyæmia, where micro-organisms are undoubtedly present in certain parts of the circulation, or in cases of abscess formation where we cannot in all cases assume that the micro-organisms are as definitely localized as is the case in pyæmic abscesses, suppuration is set up at one or more points, whilst it is entirely absent from others. We must therefore assume that organisms introduced at one point, and into comparatively healthy tissues, are killed off; whilst organisms which make their way into less resistant, unhealthy, or weakened tissues can multiply and give rise to localised suppuration. Although this is undoubtedly true, we may accept it as proved that in most instances pyogenic or pathogenic organisms have little power of maintaining their full vitality during their passage through the protective epithelial and lymphoid cells of the alimentary canal, say, and that in most cases, even when there is actual disease, they are so far weakened that their destruction is ensured within a comparatively short time, even by the weakened agencies (whether they be phagocytic or biotoxic) which ordinarily interfere with their advance. In the case of an incised or contused wound, where a considerable mass of tissue is devitalized and there are large quantities of serous fluid, which is not constantly brought into contact with living tissues, and to which new nutrient material cannot be brought, and from

which excretory products cannot be removed, we have of course all the conditions necessary for the growth of micro-organisms, a growth which will go on most luxuriantly should any seed material be allowed to find its way to this prepared soil.

WATER AS A LOCAL ANÆSTHETIC—ITS DISCOVERY AMERICAN  
AND NOT GERMAN.

Dr. Dawbarn, of New York, in a letter to the editor of the *Medical Record*, Nov. 14, 1891, says:

For some time past an item has been going the rounds of the press, both medical and lay, in this country, to the effect that a German surgeon, Dr. C. L. Schleich, has recently shown by experiments upon himself and his assistants, that water is a local anæsthetic when injected hypodermatically. This first appeared, I believe, in the *Deutsche Medizinische Zeitung*, No. 66, 1891. The *Medical Record*, of September 12, 1891, among other journals, briefly mentioned it.

I have waited since then, expecting as a matter of course that some one would come forward to correct the idea that this discovery is anything new, for many physicians besides myself must know that it is an old story.

In 1885 I called on Dr. Wm. S. Halsted, then of this city, now Surgeon-in-Chief at the Johns Hopkins Hospital in Baltimore. I was at that time making some investigations in regard to local anæsthetics, and Dr. Halsted was better informed than myself.

In the course of our conversation, Dr. Halsted remarked that he had recently been using water by the hypodermatic needle as an anæsthetic for small operations, and with success; that only the day previous he had employed this method in the removal of a small tumor from a patient living on the same street in which his office was situated; and that he had found that this plan succeeds best when the water is thrown into the skin, not beneath it; in other words, that the more superficial the incision is to be, the more satisfactory will be the anæsthesia by water.

I was much interested in this statement by Dr. Halsted, and in order to satisfy my curiosity as to just how the water obtunded sensation, made a few experiments upon my own person. It occurred to me that possibly the anæsthesia might be mechanical only, and due to pressure by the water upon the sensory nerve endings. In one of these experiments I tried to produce an equal or greater amount of pressure by other means, and then see whether sensation was abolished thereby. Dr. F. A. Manning, of this city, assisted me on this occasion. A hypodermatic needle was attached to the tube leading from my compressed air receiver, which had been pumped to a 40-pound pressure. The needle was now inserted beneath the skin of my left forearm, and the tap turned on slowly. The air distended the sub-cutaneous cellular spaces and then stretched the skin to tenseness and the production of very considerable increase in circumference of the limb. We continued until the crackling feel of sub-cutaneous emphysema could be noted on pressure, from the fingers to and including the shoulder, and the skin of the forearm felt to me almost as tight as a drum-head.

The æsthesiometer was used both just before and upon concluding this experiment; and, briefly, it was shown that while some numbness was produced, the sensation was not enough abolished to permit a cutting operation without pain, and that water probably has an analgesic property of its own.

As an additional evidence that the idea of analgesia from sub-cutaneous use



of water is nothing new, I quote the following passage from Bartholow's "Materia Medica," 5th edition, 1885, p. 690; subject, Aquapuncture: "It is a remarkable circumstance that aquapuncture has the power to relieve pain in a superficial nerve. So decided is this effect that there are physicians who held that the curative effect of the hypodermatic injection of morphine is due, not to the morphine, but to the water."

#### COMA AND DROWSINESS AS THE ONLY SIGNS OF EPILEPSY.

In discussing certain of the more unusual phenomena of epilepsy, Dr. Wilks (*British Medical Journal*, Jan. 2, 1892) comes to the question whether cases of epilepsy occur in which the only manifestation of its presence is the phenomenon which usually succeeds to the ordinary attack—the sleep, drowsiness or coma. He says:

I now ask, May this be the only symptom of epilepsy? I have reason to think it may, and to this part of my subject I wish for the opinion of the society either for or against it, as I think nothing much has been written upon it. There may be those present who would object to coma forming the essential or only part of the epilepsy, seeing it would not accord with their definition or theory of the disease; but I am at present putting aside all considerations of this kind, making my paper purely clinical.

A young lady, aged 19, gradually became insensible, and fell into a deep sleep; when awakened went to sleep again. After an interval of some weeks she had another attack, when she fell into a state of almost complete insensibility, and slept for hours. She has had similar attacks since. Nothing was observed in the shape of convulsion or twitching of the muscles before the coma came on, but on closely questioning her as to her feelings before these attacks, she said she sometimes experienced a strange feeling in her right arm, leg, and face.

A gentleman of middle age was under my care for symptoms of a syphilitic nature, having nodes on the head with much pain. He one day, whilst sitting at dinner with his niece, who took charge of him, complained of feeling unwell and sleepy, and said he should go to bed. He walked upstairs and was assisted in to bed; he soon fell into a deep sleep, from which he could not be roused, and a medical man was sent for. He was found to be in a profound coma, so that nothing could rouse him. I then saw him and we all thought he was dying, but after about ten hours he became wakeful and shortly came to. On the following day he was again downstairs as usual. It was clear that nothing of an apoplectic seizure could have occurred. About two or three weeks afterward he was seized with a true epileptic fit, followed by profound coma, which lasted several hours, as in the previous attack. He again quite recovered, but subsequently had another. It occurred in the evening, when he began to feel heavy and went up to bed, and soon sank into a comatose state. He lay thus for several hours as before, and then recovered. His niece and his nurse, who were quite prepared for a fit, on the closest questioning, declared that he had no warning or premonitory symptom of any kind before the coma came on. The niece was always watching him, and is sure that the slightest twitching of the face would have been noticed by her. It seemed to her, and also to me, that he would fall exactly into the same coma as he did when he had the regular fit.

Now, if coma be the only symptom of epilepsy, we may ask whether a partial insensibility may be of the same nature. I have already alluded to the mental aberrations of epileptics—how they will walk about in a dazed condition and be guilty of strange acts, and how such mental states may sometimes be the only indication of the paroxysm. Now, I ask, may such a condition occur and have

epilepsy for its nature and pathology without any other symptoms ever having existed? For example, a boy of 14 was brought to me, who was said to be intelligent and had obtained prizes at his school. In two years he had had several attacks of the following nature: His mother would observe that when he came home he would seem very dull, sit in a chair and not speak except when addressed. He would be led up to bed or led anywhere like an automaton or a person hypnotised. He had no fit or loss of consciousness; had several attacks of this kind. The last having continued three days, she brought him to me. He sat down in my study and said nothing except in short words when addressed. He walked into other rooms when I told him, and then came back, doing anything he was bid. He had no other objective symptoms whatever. I saw him some months afterward, and heard that the attacks were less frequent and shorter. He was a bright, intelligent boy, and presented a complete contrast to the patient I had before seen.

Sometimes an epileptic fit seems, as it were, drawn out; then, of course, there is no sudden falling, as, for example, a young woman, age 22, had curious attacks which her medical man supposed were of an epileptic nature, for the last six years. Whilst in the streets or elsewhere, she would feel a numbness in the leg and arm on one side; this continued for two or three hours followed by headache. Sometimes the sight would fail on one side, but she never lost herself. If the attack came on in the day, she was unfit to go on with her work, for as a rule she wanted to sleep for hours afterward. If one could imagine a fit which is usually ail over in so many minutes protracted for several hours, one gets a notion of this case. Another case somewhat similar was that of a young man engaged as a clerk, and who for the last six years has had strange attacks. He feels a numbness creeping over his leg or arm on one side, and sometimes vision fails on one side. This feeling may last two or three hours, and is then followed by headache, which also lasts for some time, and then sleep comes on. If these attacks occur during the day, he is obliged to desist from work, as he feels headachy, sleepy, and generally queer. He never loses his consciousness. What he described was an epileptic attack long drawn out, an attack in which all the symptoms were spread out over a length of time—the greater part of a day. If they had been compressed into a short period they would have constituted an ordinary epileptic fit. In his case there obviously could not have been any loss of consciousness.

#### ONOMATOMANIA.

Under the name "onomatomanie," says the *Lancet*, Drs. Charcot and Magnan have recently described some curious forms of functional derangements of the faculty of speech. These derangement occur in certain neurasthenic patients, and are quite distinct from any variety of aphasia or aphemia. M. Séglias of the Salpêtrière, in a recent paper, describes five varieties of the affection. In the first, the chief feature is an agonized effort to recall some word; in the second, the sufferer seems possessed by some word, and under an irresistible impulse to go on continually repeating it; the third variety is characterized by the patient attaching some peculiar and dreadful meaning to some commonplace word; in the fourth, the patient attaches some talismanic influence to certain words, and goes on repeating them as a safeguard to himself; while in the last variety the individual is impelled, as it were, to spit out some word like a disgusting morsel. According to M. Séglias, a word is "a complexus of images, localized in certain centres of the cerebral cortex, the images being partly auditive, partly visual, partly motor. Thus, the characteristic feature of "onomatomanie" is

just the irregular action of one or several of these verbal images, resulting from some functional disturbance of the corresponding centre."

In what is called simple "onomatomanie" the chief feature is that the patients are generally possessed with the idea of recovering a word which escapes them. Although the word is quite familiar to them, although they can give its significance, state the place where they have read it or the moment at which they have heard it, they appeal vainly to their memory to recall it. The result is an agonized effort to recall the word, and presently the patient hears, as it were, the word vibrating at his inner ear, and he becomes calm again. In another variety of the affection it is the articulate part of speech which is at fault. The patient knows the word, sees it written, as it were, visibly before him, but he is quite incapable of articulating it. Perhaps he utters some synonym of the word or some word resembling it in certain letters, until suddenly the word is found and the painful crisis ends. More curious still are those cases in which the patient seems possessed by a word as if by a demon. Sufferers state that they hear the word constantly resounding in the head, or sometimes the word seems to fade away in a sort of distant echo. The attacks may come on each time the patient meets certain words in reading or hears them accidentally pronounced. M. Séglas mentions the case of a woman who each time she met the word "rage" seemed to feel the word persisting before her eyes. Such cases shade off into cases of genuine hallucination, in which the patient hears imaginary words constantly sounding, or sees them written in the air. Other patients are tortured by the fear of uttering gross or compromising expressions, and often ask the bystanders what they have just said. Others, again, present the symptoms of "echolalie" or imitative speech, and go on repeating words like a phonograph.

A second distinct variety of the affection is described under the term of "onomatomanie associée," which includes those cases in which certain words acquire some peculiar and preponderant meaning in the eyes of the patient. He may regard some word as noxious and disgusting, to be got rid of by a violent expulsive effort, or he may look on some word as possessing the power of shielding him from hurt and mischief. In one case a patient could never hear the words "Wednesday," "misfortune," "thirteen," without correcting their supposed injurious meaning by saying "Saturday," "good-fortune," "fourteen." Some patients have the idea that it is some enemy who has the power of making them hear or repeat the disquieting words. "Onomatomania" is distinguished from ordinary auditory hallucination by the occurrence of the crisis of agonizing effort and the calm which follows when the crisis has been surmounted. The prognosis is most grave in those cases in which there seems to be an erethism of the motor centres which exaggerates the intensity of the motor images and forces the patient to an irresistible impulse to expel the word. This symptom marks a cerebral disintegration characteristic of the worst forms of intellectual decline.

#### A NEW TREATMENT OF CONGENITAL DISLOCATION OF THE HIP-JOINT.

The treatment of this condition has hitherto been one of the *opprobria* of the profession. Within the last ten years, however, various operative procedures have been devised with a view of rendering locomotion more feasible; but it must be conceded that the results have been far from satisfactory. That indefatigable worker, Professor Lannelongue, has recently been led to study this disease, and on December 23, 1891, he announced to his colleagues of the Société de Chirurgie the discovery of what he considers to be a rational remedy for this malady. A dozen pathological specimens in the museum of the Hospital Trousseau show clearly that the displacement is due to the absence or, at best,

rudimentary development of a cotyloid cavity, a like absence of a capsule, and a rudimentary femoral head. By resecting the head of the femur the only result obtained is the subsequent shortening of the limb by interfering with the growth of the femur. Nor is the obvious indication to create a new acetabulum fulfilled by detaching a periostic flap. Mindful of the sclerogenic properties of zinc chloride discovered by him, M. Lannelongue has utilized his method as a means of raising a ridge of new bone round the head of the femur, and so preventing its displacement. On November 17th he performed this operation on a little girl, aged three, the subject of this disease. The patient being under the influence of chloroform, and the limb being maintained in extension, twenty drops of a 10 per cent. solution of  $Zn Cl_2$  were deposited by means of a syringe on the surface of the bone at eight different spots just above the femoral head. A week later a hard osseous ring was clearly perceptible at this situation. A fortnight after the first operation a second injection of the same solution was practised, with the effect of still further accentuating the acetabular ridge. The tiny subject of this interesting experiment was presented at the meeting. The profession will await with curiosity the ultimate result of this novel essay in the field of constructive surgery.—*Lancet*.

#### THE DIAGNOSIS OF PLEURAL EFFUSION.

In a contribution to the *Lancet*, January 9, 1892, Dr. Lindsay says:

I pass on to consider the question, "Is the diagnosis of pleural effusion from pneumonic consolidation ever impossible?" There are some good clinical observers who teach that there are many cases, especially in children, where it is impossible to feel sure of the presence of fluid before inserting the needle, the physical signs being indistinguishable from those of pneumonic consolidation. This is no doubt a consolatory doctrine, but I think we should pause before assenting to a proposition which, however convenient to ourselves, is hardly flattering to the resources of our art. I am disposed to believe that cases in which the thorough application of the various methods of physical examination will leave a real doubt upon our minds are few in number, though I do not deny that now and again, though very rarely, a case presents itself in which the physical signs are puzzling and conflicting. In cases of doubt I am accustomed to rely mainly upon two signs, and I have very rarely found them to fail. Those two signs are 1, the diminution or absence of the normal vocal fremitus, and 2, the displacement of organs, especially the heart. The former of these, though not absolutely diagnostic, is certainly almost invariably found where fluid is present, and is excessively rare in any other condition. The displacement of organs, especially the heart, is diagnostic unless there are grounds for suspecting some other cause for it. I believe that attention to these two points, together with the careful mapping out of the area of dulness, will make the distinction between pleural effusion and pneumonic consolidation usually easy. The character of the breathing is not to be depended upon in doubtful cases. Bronchial breathing is quite common in pleurisy, and cannot be distinguished from the breathing of pneumonia. Nor is vocal resonance any help. The sound of the voice heard through fluid is quite variable, and may be normal, or simply faint, or bronchophonic, or ægophony may be heard. The history of the case and the course of the temperature will usually afford some guidance. While, therefore, I believe the difficulty of distinguishing pleural effusion from pneumonic consolidation has been sometimes overstated, I have notes of a case in which great difficulty arose.

## PICHI IN CYSTITIS.

Pichi (*Fabiana imbricata*) is a plant from Chili, and was brought to the notice of the profession by M. L. Boyer, in France, in 1886, for the treatment of cystitis and urinary affections. M. de Laval advises the use of a fluid extract made from the young twigs of the plant, and not, as used by the natives, an infusion of the woody portion, which is less active. For cystitis the following formula is recommended (in cases of Bright's disease it is contra-indicated):

R.—Ext. pichi fluid	· · · · ·	℥ i.
Potassii nitratis	· · · · ·	℥ i.
Syr. simplicis	· · · · ·	℥ iij. M.
Sig. A teaspoonful every three hours.		

## THE UNTOWARD EFFECTS OF SULPHONAL.

An editorial in the *Montreal Medical Journal*, Jan., 1892, says:

The injudiciousness of claiming for recently introduced drugs freedom from untoward effects after a few trials is well exemplified in the case of sulphonal. This drug, which has now been in use for a period of three years, possesses an undoubted hypnotic action, and has been extensively employed. When given in single and moderate doses it is, as far as we know at present, not followed by any disturbance. When given, however, in large doses, or in moderate quantities for some time, some very unpleasant and possibly fatal effects may follow. Recently, Jolles, of Vienna, has reported two cases where it is probable the continuous use of sulphonal was the direct cause of death. In both cases the drug had been administered to procure sleep in insanity. The urine had a reddish-brown color, due to the presence of hemato-porphyrine. The fatal result was considered to be due to the destruction of the blood.

In the administration of sulphonal it is all important to administer the drug fully dissolved, otherwise, if given continuously, it may accumulate in the intestines in sufficient quantity to bring about symptoms of marked intoxication. This danger is intensified by the obstinate constipation which frequently attends the repetition of the agent. Sulphonal is best administered in three or four ounces of hot beef tea, care being taken that it is thoroughly dissolved. Renal inadequacy is a contra-indication to the employment of repeated doses, as elimination is prevented and the danger of intoxication in consequence increased. In addition to the blood changes referred to and constipation, sulphonal induces aaxia with manifest weakness of the muscles of the extremities. Lowered temperature and slowness of breathing have also been observed. Visual and auditory hallucinations are uncommon effects. With care we believe it is possible to avoid all these disagreeable effects, or at any rate such as are of gravity, by attention to the following directions:

1. The maximum doses should not exceed twenty grains.
2. It should be thoroughly dissolved.
3. The drug should not be given continuously for more than a few days, and then only when purgatives are employed to counteract its astringent action.
4. It should not be given continuously in cases of renal inadequacy.

Medical Items.

It is said that ten drops of the tincture of gelsemium every four hours will almost invariably relieve that painful condition of backache, commonly called lumbago.

When ordinary means fail to check post-partum hæmorrhage, dip a piece of gauze or cotton into turpentine and introduce it into the uterine cavity. Contraction is produced and hæmorrhage will cease at once.

For cold in the head, there is no better remedy than gelsemium. One good, large dose, say ten minims of the fluid extract, taken upon going to bed, will effectually dispose of this troublesome and uncomfortable affection. One dose is usually sufficient.—*Med. Summary.*

The complaint in a suit against Dr. William T. Bull, to recover damages for malpractice, was recently dismissed in a New York court. The suit was originally brought against the New York Hospital for an operation that it was complained was not successfully performed by Dr. Bull. The verdict on this issue was for the hospital. Suit was then brought against Dr. Bull, with the result stated.—*Med. News.*

The *Medical Press and Circular* for Nov. 18th reports the death of a young medical man by an attack of diphtheria contracted from the bite of a patient. Dr. Hensley, of Newton Abbot, attended a child suffering from the disease and was bitten while making a topical application to the patient's throat. The outcome of this inoculation was a virulent form of the disease, which carried him off in a short time after the death of his patient.

Lovell Gulland is not satisfied with any of the duties heretofore assigned to the tonsils, and now claims that they elaborate white blood corpuscles. He concludes that many of the corpuscles enter the circulation, but is confident that their main office is to stand guard on the surface of the tonsils and fight the disease germs taken into the mouth with food or air. If all this is true, the pathologist's disease-germ-trap, which causes so much trouble in sickness, will prove to be a physiologist's fort for the destruction of the enemy as long as the tonsils are functionally healthy.—*Medical Fortnightly.*

Cutting off warts or cauterizing them never prevents their return. Pullin recommends solutio Fowleri in doses of one to six drops daily, according to the patient's age. Others recommend tinct. iodii, ten drops, twice daily. Muehler witnessed the best effects from arsenical treatment, beginning in adults with two drops thrice daily, in children with half a drop thrice daily, and slightly increasing the dose every week. The warts crumble to pieces and disappear, especially when washing and drying the hands, so that the skin looks normal after two or three weeks. Relapses were never observed.

At the recent annual meeting of the American Chemical Society, the question of the value of carbonate of ammonia as a leavening agent in bread, or as used in baking powders, came up for discussion. The consensus of opinion was in favor of the employment of ammonia. It was stated as a fact that ammonia rendered the gluten of the flour more soluble, and that the bread in which this action was produced by carbonate of ammonia must be more digestible, and hence more healthful; and because of the extreme volatility of carbonate of ammonia and its complete expulsion from the bread in the process of baking, it is one of the most useful, most healthful and most valuable leavening agents known. These conclusions are borne out by the elaborate experiments made by Professor J. W. Mallet, of the University of Virginia, which show that bread made with a baking powder in which one per cent. of carbonate of ammonia is used, is more wholesome, because the ammonia serves to neutralize any organic or lactic acid present in the flour:

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NO. 567

## CONTENTS

### ORIGINAL ARTICLES.

Clinical Importance of Skin Dimpling in Carcinoma of the Female Mamma. By L. McLane Tiffany, M. D., Baltimore. . . . . 309

The Nervous and Mental Phenomena and Sequelæ of Influenza. By Charles K. Mills, M. D., Philadelphia. . . . . 312

### EDITORIAL.

The Boston Physicians and Street Cleaning. . . . . 321

The Earliest Symptoms of Cancer of the Breast. 323

### CORRESPONDENCE.

Paris Letter. . . . . 324

### MEDICAL PROGRESS.

Ouabain.—The European Profession as Seen Through American Spectacles.—An Ear Case. —Medical Progress in the States.—Rhus [Aromatica in Enuresis. . . . . 326

MEDICAL ITEMS. . . . . 329

## Original Articles.

### CLINICAL IMPORTANCE OF SKIN DIMPLING IN CARCINOMA OF THE FEMALE MAMMA.\*

BY LOUIS MCLANE TIFFANY, M. D.,  
Professor of Surgery in the University of Maryland.

Implication of the skin in cases of mammary carcinoma is very often noticed, and always if the disease is far advanced. It is met with in various forms, dimpling being not unusual. The skin may appear as universally adherent over a large portion of the mamma, movable with it, and not able to be picked up as a separate structure. Its hardness may be compared to a parchment coating, and the induration fades off into the surrounding tissue. This form of skin implication is not accompanied by discoloration at first, but later is characterized by a pink mottling, which becomes progressively deeper until the well known purple hue is seen not only over the mamma, but also over a portion, more or less great, of the adjacent chest wall. It occurs in diffuse carcinoma, growing rapidly, and justifies a most unfavorable prognosis.

Another form of skin implication presents an appearance not unlike the pig-skin covering of a saddle. The follicles of the skin appear to be drawn upon, while the skin itself is thickened, producing the resemblance already stated. This also will be found with no well-defined border. It may occur in patches and indicates diffuse infiltration. It occurs in the late rather than in the

\*Read before the Clinical Society of Maryland, Jan. 15, 1892.

early stages of carcinoma. Occasionally there is found to exist, more often by touch than by sight, a more or less hard band, probably lymphatic infiltration, extending from the primary tumor to adjacent glands.

Still another variety assumes the form of cords in the skin, not accompanied by discoloration, raising slightly the epidermis, visible to sight as well as recognizable by touch. The cords are manifestly lymphatic channels. The presence of shot-like points of hardness in the skin is a symptom so well-known as not to require comment.

The form of skin implication to which I desire more particularly to call attention is the well-known dimpling, which may be the first sign of carcinoma noticed either by patient or physician; and while it does not occur as the earliest sign of all, yet it may occur when the original disease is so small that attention has not previously been attracted to it. A dimpling, which is an early sign, is noticed at a single point; is not accompanied by discoloration of the skin; is not accompanied by pain, and is noticed as a depression—simply that which its name implies, a dimple, and not a deep one. So slight indeed, as to be disregarded. It has been seen by me more often in the outer portion of the breast, perhaps quite at the periphery of the gland, but never in the areola. If an attempt is made to raise this dimple from the subjacent structure, adhesion, which may be very slight, is found. Indeed, it would be proper to say that the slightly dimpled skin is not quite normally movable. It is possible in a case of carcinoma to recognize at different points that the fibrous bands passing from the skin to the mamma are so shortened as to diminish the mobility of the skin, and an attempt to pinch up the skin makes dimples—makes evident these bands of adhesion; but in the early dimpling that I speak of the adhesion is shown without the necessity of pinching up the skin. Indeed, the clinical significance of the dimple is more marked if the mamma be subjected to inspection rather than to touch. An attempt to slide the skin over the mamma, or to pinch it up, causes the dimple to become whiter than usual—bloodless. The mass of carcinoma to which the skin is adherent may be extremely small, not larger than a pea perhaps, if indeed so large, and the absence of size may be taken as a favorable indication. This is most fallacious reasoning, for a very small carcinoma will cause infiltration of adjacent glands and metastatic tumors quite as well as will a large one. It is to be remembered that the occurrence of dimpling is not the earliest indication of carcinoma. It means that the carcinoma has existed a certain time, has involved and caused retraction of the fibrous tissue extending to the skin, thus producing the dimple; hence, dimple, when seen, means that carcinoma has existed a number of months, during which time, of course, lymphatic implication may have occurred and metastatic tumors may have been formed. It is most commonly met with in fibrous carcinoma, which is of slow growth, often painless; hence, the presence of this symptom is important as showing that the commencement of the growth should be dated back. It should be accepted as a danger signal of very great importance, and one which, even in the absence of much induration, glandular enlargement, family history, etc., justifies immediate operation. I do not call to mind any other disease giving rise to a like symptom, and all the more important is it not to pass over its presence and wait further development, for thereby the patient's life is jeopardized. Women in whom I have noticed this sign of carcinoma have presented an exceptionally healthy appearance. Dimples may gradually change to fissures as disease advances, the general direction of the fissures being toward adjacent glands, suggesting lymphatic involvement. Dimples are exceptionally



multiple. Many forms of skin infiltration are seen in recurrent carcinoma, but not yet has it been my fortune to meet with an example of dimpling, hence I am inclined to look upon it as a sign of primary disease. A dimple having formed, persists unless destroyed by ulceration, together with adjacent structures; its base does not return to the skin level. The following illustrative cases are presented:

CASE No. 1.—A white woman of middle life, the mother of grown children, consulted me. I found that she had in the right breast a tumor, infiltrating, without a well-defined border, and probably one inch and a half by half an inch in size. Over it was a well-marked dimple, the bottom of which was whiter than the surrounding skin. It had existed fifteen months and she had paid no attention to it until recently, considering it a matter of small importance. According to her own account, the lump, which now could be felt beneath it, had appeared only recently, but the dimple and its firm adhesion to subjacent parts showed this statement of her's to be erroneous. The axillary glands were enlarged, and a suspicious hardness was felt above the clavicle on the same side. The woman was well nourished.

CASE No. 2.—A white woman, aged 51, the mother of adult children, noticed in the left mamma an apparently insignificant dimple, which excited her surprise but not anxiety. I saw her many months later. The following condition of affairs was present: Left mamma not at all enlarged, normally movable over the chest, and presenting in the outer and upper quadrant a dimple half as large as the tip of the little finger. The skin was not discolored, and not elsewhere abnormally adherent to the breast. The glands adjacent to the coracoid process were enlarged, as well as those above the clavicle. The left arm was swollen—œdematous, and much pain in that extremity was present. The skin of the left arm was darker than usual, and a purple blush extended down the back over the scapula and over the axilla. The territory occupied by this discoloration corresponded fairly well with the territory accustomed to send its blood through the subclavian. The extensive growth above the clavicle was adherent firmly to the vertebræ. No operation was deemed expedient, and the patient died a very few months later.

Beneath the dimple in the mamma was a point of infiltration not as large as the last joint of the thumb. Here the growth first commenced, and during fifteen or twenty months the progress of the disease appeared to be at the primary site very slow, while general involvement of the body elsewhere, sufficient to cause death, took place. Had the patient had a large tumor in the breast, she could not have failed to recognize its importance, whereas, in consequence of the very small growth at the primary site of the disease, the patient was lulled into temporary security, and increase elsewhere took place. The patient's fears were not aroused until shortly before she consulted me.

CASE No. 3.—A white, decidedly stout woman, 55 years of age, whose menstrual life had ceased eight years ago, married, childless, consulted me on account of a fissure, probably half an inch deep, which existed above, and to the outer side of, the left nipple. The sides of the sulcus being separated, showed that the bottom was more white than skin should be. It appeared to extend into the mamma, and beneath it a disc-shaped induration could be recognized. In the axilla were a number of glands. The diagnosis of carcinoma was plain. The fissure had commenced as a small dimple eighteen months before, and had gradually deepened until it presented the appearance already stated. Her family physician had first seen the growth a few days before I was consulted,

No pain or other symptom had been complained of until within a month, when occasional shooting pains were noticed, which caused her to seek the advice of her family physician.

These three cases well illustrate the fact that the absence of a large tumor lulls the patient's mind into security, during which the disease advances. It may be questioned whether the same absence of tumor formations does not also occasionally deceive the medical expert. The pitting is due, as is well-known, to a shortening of the processes of superficial fascia which pass from the under surface of the skin to the mammary gland, and is independent of visible skin infiltration, and if at all marked, is accompanied by a whitening of the skin at the point where the band of fascia is attached, traction doubtless diminishing the lumina of the capillaries.

I do not think it is possible to say how soon skin infiltration is noticed after the commencement of the growth, for who is able to say when the growth began? An attempt to give a date to the commencement of a carcinoma will be founded on no accurate data. The patient is not aware of the beginning of growth, since, before the tumor has attained any size, it had been in existence a certain time, and the patient only notices it after reaching certain dimensions. Rapidly growing carcinomas do not show this sign. Skin dimple accompanied by cachexia implies metastatic growth, for the local disease being small, the cause of the cachexia must exist elsewhere.

If it is accepted that the dimple means that the carcinoma has existed during a certain time, the prognosis after operation must necessarily be uncertain.

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### THE NERVOUS AND MENTAL PHENOMENA AND SEQUELÆ OF INFLUENZA.†

BY CHARLES K. MILLS, M. D., OF PHILADELPHIA.

All practitioners have been struck by the prominence of nervous and mental phenomena in influenza; and much has been written, but mainly in a desultory way, about the symptoms of the disease which are referable to the nervous system, and its more or less persistent nervous and mental sequelæ. The part played by the nervous system in the etiology and history of the disease has been variously interpreted. One holds that it is a "nervous disease," without explanation; another describes it as a pneumogastric neurosis; another as a neuropathy due to ptomaine poison. According to Blocq, cited by Church,<sup>1</sup> the primary infectious action takes place upon the nervous system during the disorder, while sequelæ are to be attributed to secondary infection from ptomaines. Chester Morris<sup>2</sup> of Philadelphia, advances the theory that the general symptoms of influenza may be traced to a derangement of function, or partial paralysis of the pneumogastric nerve, and that the affection is brought about by conditions of the atmosphere, which particularly tax the cardio-pulmonary apparatus which is regulated by this nerve, a view which, after all, relegates the disease to an atmospheric or infectious cause. Graves long ago referred the bronchial and pulmonary symptoms of grippe to lesions of the nervous power of the lungs, and Blakiston regarded it as a disorder of the nervous system, with concomitant de-

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†Read before the Philadelphia County Medical Society, January 13, 1892.

1. Church, Chicago Medical Record, 1891.

2. Morris, American Lancet, March, 1891.

rangement of the organs of digestion, circulation, etc. Levick,<sup>3</sup> who cites the last two authorities, holds that certain symptoms are produced when the poison is expended on the sensorium, and certain others when its influence is chiefly exerted on the respiratory centres.

The analogies or relationships between influenza and other diseases generally recognized as belonging to the nervous system, either primarily or because of the situation of their most notable lesions, have been strongly brought out by able writers, as by Levick, for example, who has even suggested that epidemic cerebro-spinal fever, or cerebro-spinal meningitis, may be simply a malignant form of influenza, a view to which he was led because of the resemblance in the symptoms of the two diseases which differ in degree rather than in nature, and also because for three centuries the two have occurred coincidentally or in close sequence.

Grasset and Rauzier,<sup>4</sup> in a monograph on the grippe of 1889-90, lay great stress on the enormous predominance of the nervous over the catarrhal elements in the epidemic, as evidenced in the high fever, great cephalalgia, the marked delirium, the widespread pain, and the excessive nervous irritability. They refer to cases communicated by M. Coustan, in which the entire symptomatology of the disease seems to have reduced itself to a horrible migraine. They review the literature which shows that writers of various countries are unanimous in proclaiming the importance of the nervous element—referring to Austrian, Russian, Belgian, German, English, and Polish contributions.

According to Schmitz,<sup>5</sup> who read a paper on the subject before the Psychiatric Society, at Bonn, influenza is a disease of the nervous system with secondary involvement of the heart, lungs, and digestive organs. In several hundred cases which he observed the nervous symptoms were always primary, followed in every case by secondary involvement of the other organs.

Any attempt to classify the nervous and mental phenomena of influenza must be attended with great difficulties. There are, in the first place, symptoms and conditions which, although manifested in non-nervous organs, are directly traceable to a nervous origin; secondly, affections which would be recognized by all as properly referred to the nervous system; and, thirdly, affections occurring in nervous tissues and organs, although, strictly speaking, not nervous diseases.

I will refer very briefly to the first of these classes, although of much importance. I will not, however, discuss the nervous origin of the fever of influenza, nor will I attempt to explain the catarrh, indigestion, etc., on some neurotic theory, as such a method might lead us anywhere, and for our present purposes would be unprofitable. I wish simply to emphasize the fact that some of the most prominent pulmonary, cardiac, and vascular affections of influenza can best be explained on neural theories. Many personal observations have led me to the conclusion, not new, which has recently been well presented by Elliott,<sup>6</sup> of New Orleans, that the pneumonias of influenza are often due to vasomotor paralysis, that they are, in fact, forms of blood stasis or passive congestion from vasomotor paralysis, which in its turn is dependent upon the action of the infection upon the pneumogastric centres and the nervous system in general. A distinct difference can be made out between the true pneumonic lung and this "grip-

3. Levick, *Am. Journ. Med. Sci.*, January, 1864, and republication in pamphlet form, with notes of the influenza of 1889-90.

4. Grasset and Rauzier, *Lecon sur la Grippe de l'Hiver, 1889-90*; Montpellier and Paris, 1890; Monograph of 98 pages.

5. Schmitz, *Allgemeine Zeitschrift für Psychiatrie und psychisch-gerichtliche Medizin*, 179, 1891. Cited in *American Review of Insanity and Nervous Disease*, December, 1891.

6. Elliott, *The Climatologist*, Vol. I, No. 1, August, 1891.

lung," as it has been termed by Elliott. Graves long ago attributed the œdema of the lungs which occurs in influenza to an affection of the vagus.

Many disorders in various parts of the body are best explained on this theory of local vasomotor paralysis, although it is not necessary to attempt to force this explanation for all. Hæmorrhages, minute, or even of considerable size, occurring in diverse localities, as in the retina, membrana tympani, and internal auditory apparatus, or in the skin, or mucous or serous membranes anywhere, may be due to deficient vasomotor tonus. Brain, kidneys, liver, or pelvic organs may suffer from forms of passive hyperæmia, subacute or chronic, which are in fact due to forms of vasomotor palsy. Occasionally we meet with cases of vasomotor disorders of the extremities, such as flushed or pallid fingers.

The peculiar forms of pulse, and the uncertain or perverted action of the heart, extending in some cases to cardiac palsy and death, are in a strict sense nervous phenomena due to paralysis, partial or complete, of the inhibitory apparatus of the heart.

Let me take up these symptoms and affections which would be clearly recognized as belonging to the nervous system.

Great nervous and mental prostration, both as an acute manifestation and as a persisting sequel, has engaged the attention and required the treatment of all practitioners. The mental depression often present as an initial symptom has been, in some cases, simply overpowering. Some of the patients are affected like individuals whose mental and motor centres have been poisoned to the limits of human endurance, while still permitting the retention of consciousness. In other cases even consciousness itself has been overwhelmed.

Not a few patients who suffered from attacks of influenza during the early period of the present epidemic are still victims of profound neurasthenia. I refer now to cases which are not distinctively of melancholic type. These neurasthenics are unable to endure a fair amount of work, their nervous forces are soon routed; they are weak, worrisome, and unrecuperative. The cardiac weakness which has been left is undoubtedly in part the cause of this neurasthenia, and with reference to this, Church says that "the persisting neurasthenic condition, which so usually follows influenza, is attributed by some to cardiac weakness of nervous origin, and this contention is not without weight, if it is observed that even after appetite, sleep, body-weight, and physical functions have been long restored, the slightest exertion immediately produces disproportionate fatigue accompanied almost invariably by either a retarded or more frequently accelerated pulse, and rarely by præcordial distress and even by angina pectoris."

Curtin and Watson,<sup>7</sup> whose experience in influenza has been enormous, say that although general nervous prostration often extended over long periods without any discoverable local cause, it was always worth while to examine the urine with care. "Sometimes a nephritis, sometimes a faulty digestion or hepatic inaction, seemed to underlie the general condition in latent form. These cases, by enforced rest and attention to local complications, gradually recovered. These cases and nervous cases generally, were very disappointing when sent to the seashore during convalescence."

Among organic nervous diseases which have developed during the influenza or have been left in its wake, are in the order of their frequency, so far as my personal observation has gone, neuritis, meningitis, myelitis, and cerebritis, or various combinations of these inflammatory affections, as, for example, concurrent neuritis and myelitis, meningo-myelitis, or meningo-encephalitis.

<sup>7</sup>: Curtin and Watson, *The Climatologist*.

Probably no single affection of the nervous system has been so common during and after the grippe, and particularly as a sequel of the disorder, as neuritis.

Almost every variety of neuritis as regards location and diffusion has been recorded, and has come under my personal notice. Multiple neuritis, while not common, has not been rare; and I have seen a concurrence of this affection with poliomyelitis in the same case. Isolated neuritis of almost every cranial nerve has been recorded, with such resulting conditions as optic atrophy, loss of smell and of taste, ophthalmoplegias, both internal and external; oculo-motor, facial, and bulbar or pseudo-bulbar palsies of various types, including true pneumogastric paralysis. Several cases of specially located affections of the sympathetic ganglia or nerves have been recorded. Of the forms of local neuritis most common might be mentioned the supra-orbital, intercostal, sciatic, and plantar.

An interesting case of neuritis with a myxœdemoid condition of the limbs presented herself at the Philadelphia Polyclinic recently. She had a sharp attack of influenza five weeks ago, having been in good health up to that time, except five years since, when she suffered for several weeks with inflammatory rheumatism. On recovering from the influenza, the attack not having been especially marked with nervous symptoms, she was extremely weak in the legs, and was scarcely able to drag herself around. In a few days her feet and legs began to swell and to be painful, and soon became of enormous size and exquisitely tender. She has gradually improved, but still has a condition of firm swelling, which does not pit on pressure, from her knee to her ankles, and she also still has great tenderness on squeezing the feet or ankles, or in handling the nerves or muscles of the limbs. She has no cardiac affection.

The articular pain and other so-called rheumatic manifestations so numerous during and after attacks of the grippe, are after all best explained on the theory of infectious neuritis or myositis.

These cases with articular and other pains, and with swelling, recall the endemic or epidemic form of multiple neuritis known as beri-beri, in which the chief phenomena are œdema and paralysis of the limbs, with marked pain, hyperæsthesia and paræsthesia, followed later by anæsthesia, lost knee-jerk, and depressed electrical reactions. Myositis certainly, and probably also periostitis, occur as complications or sequences of the influenza, and usually in association with neuritis of some type.

Many of the reports speak of the frequent occurrence of various neuralgias. Doubtless a distinction is seldom made by observers and recorders between neuralgia and neuritis, which are or may be separate affections. Practically these cases should be regarded as neuralgic, in which pain is referred to certain nerve lines or radiations; but in which pain on pressure, and the other phenomena of neuritis, such as anæsthesia, vasomotor and trophic disorders, and even paralysis, are absent. In my own experience the cases which could properly be diagnosed as neuritis are by far the most common. The distinctively neuralgic pains are probably due to toxæmically depressed or exhausted sensory nerve-roots or centres in the cord and bulb.

Of diseases of the spinal cord proper, occurring as complications or consequences of influenza, the reported cases are not numerous, but they are none the less important. A few cases of myelitis have been put on record by native and foreign observers—one that I recall in which all four extremities were paralyzed. As would be expected, in accordance with the analogies with other infectious and toxic diseases, anterior poliomyelitis is the most common type. I have had several cases of temporary paralysis of one or more limbs, which,

owing to the absence of pain and cerebral symptoms, were apparently spinal in their origin, and probably light forms of inflammation. Concurrent multiple neuritis and poliomyelitis has already been referred to as having been observed by me in one case, in which the neuritis, which was not severe, soon disappeared, but a limited paralysis, evidently spinal in character, was left behind.

Several observers have reported cases of bulbar paralysis, and one striking example of the disease, attributed to the grippe, has come under my own observation, although exactly how far the influenza was responsible it is difficult to say. This patient, a clergyman, had a severe attack of influenza in May, 1890, and during its progress continued to work, and ate but little. In a very short time he noticed he was losing power in his hands, which soon atrophied. In January, 1891, he began to have difficulties of speech, and, briefly stated, the case went on until November, 1891, when he was first seen by me; his symptoms were those of well-marked bulbar paralysis, with progressive muscular atrophy, chiefly involving the upper extremities.

In accordance with analogy, we would expect the occasional occurrence both of nuclear polioencephalitis, and even rarely Strumpell's cortical polioencephalitis. One or two of the few cases of probable polioencephalitis of the latter type have occurred in patients suddenly stricken with fever, loss of appetite and other symptoms which may have been due to infection.

Priester<sup>8</sup> has reported the case of a man fifty-four years old, who was taken with influenza in February, and in the beginning of March was seized with extremely violent headache which resisted all medication, and later the patient became deeply somnolent, remaining in this condition for four weeks; he could be aroused, but was apathetic and soon slept again. Reflexes and temperature were normal; pulse from 40 to 60. The patient had no paralytic symptoms, and slowly improved. His affection, according to the reports of the case, closely resembled Gerber's disease—paralyzing vertigo—though the latter is a disease of the warm weather. Tumor could be excluded by the absence of all focal symptoms a year before the attack. The most probable cause he believed was a pathological process, involving the central gray matter of the third ventricle, which would bring the disease into close relation with the polioencephalitis of the nuclear type. Dr. G. J. Kaumheimer, who translated this report for the *Review of Insanity and Nervous Diseases*, December, 1891, observed an exactly parallel case which originated in April, and lasted into July before recovery took place.

That meningitis, either cerebral, spinal, or cereb-ro-spinal, occurs during the decline of the influenza cannot be doubted in the light of the evidence which has been presented by various observers, and particularly during the epidemic of the last three years. It is, however, a comparatively rare concomitant or complication. Some of the facts adduced as proofs of the existence of meningitis, and some of the cases reported as examples of the disease, are clearly instances of improper interpretation. The intense cephalalgia and rhachialgia; the atrocious pains variously localized in the face, trunk, limb-nerves, muscles or joints; the vigilant delirium, with hallucinations and delusions, sometimes assuming great gravity; the intense vertigo, with or without nausea and vomiting—these and other well-known nervous manifestations which are so prominent in many cases at the initiation of the disease, are not necessarily evidences of meningitis, or even of meningeal hyperæmia. Rather they are due to an overwhelming

8. Priester, *Wien. Med. Woch.*, No. 27, 1159. In *American Review of Insanity and Nervous Diseases*, December, 1891.

toxæmia of the nerve centres of the brain. Severe and terrible in character at first, they frequently pass away almost as rapidly as they came, which would not be the case if they were evidences of a true meningitis. The enormous prostration which is left behind shows that the centres of nervous energy have been subjected to a depressing agency of great virulence, not that merely enveloping membranes composed mainly of fibrous tissue and blood-vessels have been congested or inflamed. No reason could be given why such congestion or inflammation should leave such results.

The reports of cases terminating fatally because of meningitis, and even the reports, personal or official, of the frequent occurrence of this affection, must be received cautiously, and sometimes incredulously. They are only to be relied on when confirmed by autopsies, or when from observers who are accustomed to closely differentiate the meaning of nervous symptoms, and particularly of pain.

It may also be worth while at this point to refer to the somewhat frequent diagnosis of chronic meningitis as one of the sequelæ of the disease. This diagnosis is usually made because of the presence of more or less persistent pain in or on the head. Experience has led me to believe that this pain is usually neurotic rather than meningeal. Even deep-seated intra-cranial pain does not necessarily indicate meningitis. They may be due to neuritis, just as certainly as a pain in the hand or foot. The fifth nerve has an immense distribution within as well as outside the cranium, largely to the dura mater, but also to other tissues and parts. It is a pathological possibility to have dural neuritis without a pachymeningitis, and this is the true explanation of some pains, both acute and chronic, which are present in other diseases as well as in influenza.

The form of meningitis most likely to be present in influenza is inflammation of the pia-arachnoid or soft membranes, now often designated lepto-meningitis. From observations, corroborated by autopsies, I know that this affection may exist without pain; while pain of varying degree of severity, and usually intense, is practically invariable in pachymeningitis. Lepto-meningitis, however, is not usually without pain and hyperæsthesia as symptoms, but it may be absent, and its presence or absence will depend upon the location, extent, grade, and complications of the meningitis.

While believing that these criticisms upon the sometimes hasty and too frequent diagnosis of meningitis in influenza, and indeed in many other infectious and febrile diseases, are just and can be sustained, it remains true that a genuine meningitis, sometimes of a malignant type, may appear during the progress or closely following influenza. Some very competent observers have reported cases of this character, and in a very few instances the diagnoses have been confirmed by autopsies. The diagnosis should be made to hinge upon the signs and symptoms which would be satisfying as to the occurrence of meningitis from any cause; not alone on the presence of such phenomena as headache, vertigo, and vomiting, but on such more convincing manifestations as optic neuritis, and localized spasms or palsies, either cortical or of cranial nerves.

The fact that meningitis, and even the cerebro-spinal form, does occasionally occur in influenza, is by no means proof that this disease and epidemic cerebro-spinal fever are identical. It simply emphasizes the point with which I started, namely, that every infectious or poisonous agent introduced into the economy may produce the same or similar pathological results in the nervous system. Largely according to the vulnerability, special or general, of certain tissues and organs, will be the preponderance of this or that form of so-called disease—for instance, of neuritis, myelitis, meningitis, cerebritis, or of combinations of these

affections. All infectious and toxic diseases give neuritis as the most common acute or chronic inflammatory manifestation, although myelitis, cerebritis, and meningitis may occur. Even in cerebro-spinal fever, that I was perhaps the first to point out, multiple neuritis is a common complication; but the infection being virulent and overwhelming, we may not only have meningitis but even meningo-encephalitis, or meningo-myelitis, with all their malignant phenomena and permanently disastrous results.

Vertigo is another symptom, like pain, often improperly referred to meningeal or cerebral inflammation. It is sometimes due to such disease, but occurring in influenza it may arise from other causes, as, for instance, from extravasations into the labyrinth or other portions of the auditory apparatus.

Müller<sup>9</sup> reports the case of a man, 50 years old, who after influenza presented great physical exhaustion. In a few weeks his mind seemed affected and he became somnolent, so that he could be roused only with difficulty and would then fall asleep again. In this respect the case was much like the one reported by Priester. Pain upon pressure was present over the vertebræ, the neck was rigid, the pulse was small and irregular, the skin reflexes were diminished, and the tendon reflexes were absent. In two weeks he began to improve. The author believed the case was one of spinal cerebro-spinal meningitis, similar to that seen after infectious diseases.

Without entering into a discussion of their pathology or their peculiarities, I will briefly mention a few other forms of nervous disorder, occurring during or as apparent sequelæ of the influenza, examples of which have come under my personal observation. Convulsions have been reported by various observers, and in a few instances the convulsive habit has been established, and the patients have remained up to the time of report as cases of epilepsy. I have seen two such cases. Hystero-epilepsy and other grave hysterical phenomena have been initiated, or have recurred in cases in which the symptoms had long been dormant. Of local spasmodic affections I have seen no records, but one case of persistent clonic torticollis, with some pain and tenderness in the spinal accessory distribution, has been in attendance at the Philadelphia clinic. Two cases of facial paralysis, occurring immediately upon the heels of influenza, have come under observation.

Many affections not of, but occurring in, the nervous system have been reported as complications or sequences of the influenza. These include such affections as apoplexy, due either to hæmorrhage, thrombosis, or embolism.

Various observers have reported cases of monoplegia and hemiplegia, without indicating pathological character.

Dr. S. S. Prentiss,<sup>10</sup> of Washington, has reported three cases of cerebral apoplexy occurring during the progress of the influenza.

In cases of this character the infection of the disease acts to bring about an apoplexy both by the changes which it produces in the blood, by its effects upon cardiac action, and by the general debility induced. Such apoplexies might occur from other depressing causes; they are to be regarded not as phenomena, but rather as accidents of the epidemic.

Uræmic convulsions in patients suffering from chronic Bright's disease have been precipitated by the influenza, and it has seemed to me to have been active in lighting up lurking syphilitic diseases.

In one case of parietic dementia of somewhat irregular type, seen in consultation

<sup>9</sup> Muller, Berlin Klin. Woch., No. 37, 1890; cited in American Journal of Insanity and Nervous Diseases, December, 1891.

<sup>10</sup> Prentiss, Medical News, August 29, 1891.



the initial symptoms of the disorder were observed soon after recovery from a severe attack of grippe, the wife and friends of the patient in fact attributing the mental disorder to this attack. The probabilities are that syphilis was present, but latent, prior to the epidemic.

Purulent meningitis and brain abscesses have been somewhat frequently noted in connection with the numerous instances of purulent otitis media.

The relations of influenza to insanity have not received much attention from writers. Mairet,<sup>11</sup> of Montpellier, has recently published a lecture on the subject delivered at his clinic for mental and nervous diseases. Rush, who is referred to by Mairet, speaking of the epidemic which lasted from 1789 to 1791, and particularly of the year 1790, mentions that several persons were stricken with symptoms of insanity, and that one attempted suicide; he also speaks of several having had hallucinations of sight. Bonnet, reporting on the epidemic of 1837, cites one case which was stricken with a furious mania as the result of the grippe; and Petrequin, referring also to the same epidemic, records several patients tormented by melancholy ideas, and states that four or five suicides were accomplished or attempted at the hospitals in Paris.

The following conclusions compress into small compass so much that is valuable, with reference to the relation between influenza and psychoses, that I cannot do better than quote them. They are reported as the conclusions arrived at by Dr. Leledy, and were presented to the Medical Society of London by Dr. Savage:<sup>12</sup>

- 1, Influenza, like other febrile affections, may establish a psychopathy.
- 2, Insanity may develop at various periods of the attack.
- 3, Influenza may induce any form of insanity.
- 4, No specific symptoms are manifested.
- 5, The role of influenza in the causation of insanity is a variable one.
- 6, Influenza may be a predisposing or exciting cause.
- 7, In all cases there is some acquired or inherited predisposition.
- 8, The insanity is the result of altered brain nutrition, possibly toxic.
- 9, The onset of the insanity is often sudden, and bears no relation to the severity of the attack of influenza.
- 10, The curability depends on general rather than on special conditions.
- 11, The insane are less disposed to influenza than are the sane.
- 12, In rare instances, influenza has cured psychoses.
- 13, The insane may have mental remission during the influenza.
- 14, There is no special indication in treatment.
- 15, Influenza may lead to crimes and to medico-legal issues.

I can endorse from experience almost every one of these conclusions. With reference to the statement that no specific symptoms are manifested, it should be said that while this in a general sense is true, the most frequent type is a form of melancholia.

The epidemic influenza has impaired the *morale* of the community. Lack of spirit in work, and an apprehensiveness with reference to health, business, and all matters of personal interest, are abnormally prevalent. The hysterical have become more hysterical; the neurasthenical more neurasthenic. Hypochondria has displaced hopefulness in individuals commonly possessed of courage and fortitude. In brief, certain neuropathic and psychopathic features have been impressed upon the community. We cannot afford even to dismiss entirely from consideration the bearings of the epidemic upon the increase not only of suicides, but of other grave crimes.

Many interesting questions in connection with treatment might be discussed; but as the subject of treatment has been assigned in this discussion to Dr. Hare,

11. Mairet, Grippe et Aliénation Mentale. Montpellier and Paris, 1890.

12. Savage, *Lancet*, No. 3553, and *Medical News*, January 16, 1892.

I will only speak of one point. The use in influenza of hypnotics, narcotics, sedatives, and motor depressants is a question of particular interest in connection with the study of the nervous and mental phenomena of the disorder. The views of practitioners and writers are here decidedly at variance. Serious mental and nervous complications or actual insanities occurring during influenza have been attributed to the too free use of such chemically powerful remedies, as phenacetin, antipyrine, antifebrin, chloral, bromides, sulfonal, and paraldehyde; and our older narcotics, such as opium, hyoseyamus, conium, and cannabis Indica, have also come in for a share of blame. Persisting conditions of nervous prostration, and chronic respiratory and cardiac neuroses, have also been charged to drugs. Undoubtedly such criticisms have some foundation, but it remains true that each of the remedies named has proved itself of some value in the treatment of influenza and particularly of its nervous types. The enormous consumption of a drug like antipyrine is a practical argument both for and against its use. What Grasset has said of this remedy might with almost equal truth be said of almost any of the rest. "This agent," he says, "vaunted by some as a panacea against all manifestations of the disease, is considered by others a remedy absurd and irrational in all cases. The truth would seem to reside between these two extreme opinions."

#### TENDON GRAFTS INTRODUCED BETWEEN THE WIDELY SEPARATED ENDS OF DIVIDED TENDONS.

Dr. Rochet (*Gaz. hebdom. de méd. et de chir.*, June 20, 1891) obtained a very happy result in a case in which the ends of the divided tendons of the superficial and deep flexors of the index fingers could not by any means be brought within two centimetres of each other. The proximal and distal ends were exposed in the usual manner. An incision was then made on the palmar surface of the finger at the joint of the phalanges, where the tendon of the profundus passes between the two lips of the tendon of the sublimis, and the tendon of the profundus was divided at this point. The portion of tendon thus cut off was drawn out of its sheath, its upper end sutured to the proximal portions of the tendons of the sublimis and profundus, its lower end to the distal portion of the tendon of the sublimis. The proximal end of the small portion of deep flexor tendon which remained between the point where it pierces the sublimis and its insertion was then sutured to the lateral slips of the sublimis tendon. The patient recovered with good use of the finger.—*N. Y. Med. Jour.*

#### THE TREATMENT OF CHRONIC HYDROCEPHALUS BY PUNCTURE.

Professor Unverricht, says the *Lancet* of Dec. 12, 1891, reported at a recent session of the Dorpat medical faculty four cases of chronic hydrocephalus, which he had treated by puncture, and one of which he presented before the faculty. The patient was a boy two years and a half old, who at the age of ten days had been affected with convulsions, and at three months and a half presented a considerable enlargement of the skull. The boy was afterwards affected with strabismus, nystagmus, and general paralysis, and advanced so slowly in intellect that he was a year and a half old before he could say "papa" and "mamma." In this state he was admitted to the clinic, and puncture of the hydrocephalic head was performed at once; 75 cubic centimetres of a clear, transparent fluid, having a specific gravity of 1006.5, were obtained from the puncture. There was no reaction, and considerable improvement, both physical and intellectual, followed in time. Professor Unverricht himself is so satisfied with the result of the treatment that he is encouraged to repeat it and to recommend its general adoption.

**THE MARYLAND MEDICAL JOURNAL.**

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BALTIMORE, FEBRUARY 6, 1892.

**Editorial.****THE BOSTON PHYSICIANS AND STREET CLEANING.**

The interest recently shown by the Clinical Society of Maryland in the matter of public sanitation does not seem to have met with much attention either from the profession or from the press or from the city authorities of Baltimore. It is encouraging to learn that in the sister-city of Boston similar efforts put forth by the medical societies have met with better success. We hope that the profession of Baltimore with this encouragement will continue agitation upon the subject until the needed reforms are wrung from our City Fathers.

Believing that our readers will feel an interest in knowing just what has been accomplished in Boston, we venture to quote at some length extracts from the proceedings of the Section of Hygiene of the Massachusetts Medical Society (see *Boston Med. and Surg. Journ.*, December 31, 1891):

**REPORT OF COMMITTEE UPON THE CONDITION OF THE STREETS OF BOSTON.**

Dr. V. Y. Bowditch, for the Committee on the Condition of the Streets of Boston, stated that the committee had occupied itself in interviewing, at various times through the year, both Mayor Hart and Mayor Matthews, Governor Russell, the Police Commissioners and the Superintendent of Sanitary Police. Without arrogating too much to the medical men, Dr. Bowditch believed that the action of the Suffolk District Medical Society last year had been of great service in procuring a cleaner condition of the streets. Immediately following their action, the press had strenuously supported them and urged the necessity of greater cleanliness; and in the following autumn both candidates for the mayoralty had made the subject of special import in their message, and although there is still much room for improvement, no one can deny that the city, in the business portions, at least, is much cleaner than before, the reforms being largely due to Mr. Carter, the present Superintendent of Streets.

In all their interviews a marked cordiality has been shown to the efforts of the Committee, except by the Police Commissioners, who for some reason or other show a decided indifference to enforcing laws on the statute books for the prevention of throwing refuse into the streets by shopkeepers and others. The watering of the streets has greatly improved in the past year, doubtless due to the energetic action of Dr. H. J. Barnes, who, independently of the committee, had sent several letters to the newspapers relative to this subject. Dr. Bowditch hoped that Dr. Barnes would be added to the committee, and stated that it was their intention to pursue the same course as heretofore by interviews with various officials relative to still greater improvement in the condition of the city.

Dr. Warren: I think the work the Society has done has had its effect, and that the condition of our streets, while far from the desired point, has been much improved. This is one of the great improvements, it seems to me, this country has to make, not only for the comfort, but for the sanitary advantage of the citizens. We expend enormous sums of money for parks, for luxurious hotels, for means of conveyance; we are making great improvement in comforts and conveniences in the way of living, and yet we are almost Chinese in the standard which we set for street engineering in this country. I do not speak of Boston so much as of other cities. I think Boston compares favorably with them, but there is still a great deal to be done. In fact, the science of road engineering is in its infancy in this country; and we want to stir continually, in order, not only to gain what is now proposed, but to spur on the authorities to educate themselves up to a much higher standard of work than they have ever aspired to before.

Dr. Barnes: I desire to say something on this subject, for it seems to me we owe to the present administration, regardless of our political affiliations, recognition of the wonderful changes it has affected in the appearance of our streets, particularly when we recall the reported interview of our committee, with the municipal authorities of a former administration, where every obstacle was placed in the path of this much-needed reform.

In reviewing the report of that interview, it would seem as if all efforts had been exhausted in an endeavor to find how *not* to do the work. For years filth was allowed to accumulate between the double lines of horse-car tracks, owing to a controversy between the street railroads and the city authorities. I chanced to pass through Boylston Street last spring at the time of its removal. Piles amounting to a good horse-load, as frequent as space would permit, were scraped up for loading; and I was much surprised to observe a good stone pavement underneath, which had been hidden for years. The cross-walks are now swept; the piles of rubbish collecting in the lee of the fences of bridges and curbstones have generally been removed. Prior to this year, I often was obliged to take up from two to five bushel baskets of road detritus gathered during windy days in front of my residence; nothing of this character has annoyed me during the past season; neither have I observed the offensive odors of the streets so common a year ago.

It seems to me we can now compare our condition with that of some of the

better municipalities, and not be obliged to go as far as Constantinople or even New York to find a parallel.

An appropriation of \$150,000 last spring, three times the usual amount, was placed at the disposal of the Superintendent of Streets, for sprinkling, and the clouds of dust of former years, resembling a simoon in Sahara, have not been our unhappy experience. This branch of the municipal service has not as yet been placed on a good business basis, and excessive sprinkling has been noticed much of the time; but I am informed plans are being matured to systematize the work.

With the experience gained during the past year we may reasonably expect better service next year, and the establishment of an equable method of payment. The committee of the city council having this subject under consideration is composed of gentlemen in whom we may repose confidence.

While commending the present administration for what it has accomplished, we may congratulate ourselves for the influence we have exerted, for in this hall and by you, these reforms were inaugurated, and by your committee brought to the attention of the municipal authorities. And when we remember the successful labor of members of our profession, which resulted in the building of the intercepting sewerage system; the reform in milk inspection, which chiefly through us has been secured; the elimination of sources of pollution of our water-supply and the excavation of the storage basins of the Sudbury River, which, by the way, has practically revolutionized the practice of engineers in constructive work of this character,—we have much to encourage us in persistent effort to improve the sanitary condition of our city.

Dr. Barnes presented the following motion:

*Resolved:* That the members of the Suffolk District Medical Society, Section for Hygiene, etc., desire to express their gratification at the improved condition of the streets of Boston, and hope the effort for improvement will be continued, that we may ultimately be able to compare their condition with the best examples in other municipalities.

We hope that the perusal of the above statement will convince our weak-kneed brethren of Baltimore of two facts. First, that it is neither beneath the dignity nor contrary to the true purposes of a medical society to take an interest in public hygiene; and second, that city governments may be shamed out of their gross neglect of duty if dignified, united and persistent remonstrance is made by medical men.

At present in respect to dirt and neglect of sanitation Baltimore bids fair to "take the cake."

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#### THE EARLIEST SYMPTOMS OF CANCER OF THE BREAST.

We take pleasure in presenting to our readers in another column an extremely practical article from Dr. Tiffany on Skin Dimpling in Cancer. Such an article, containing in concise and plain terms the personal observations of a surgeon of ~~wide experience and acknowledged ability, is well worthy of careful perusal.~~

The subject is one which touches the general practitioner as closely as any in the field of surgery. It is the duty of the ordinary family practitioner to guard his patients against equally perilous extremes—neglect of early symptoms; and the suffering of those awful and well-nigh hopeless operations on cancers which have spread from the breast to the great blood vessels and other structures in its neighborhood.

The testimony of Dr. Tiffany as to the meaning of skin-dimpling in the breast is clear, concise and earnest.

Advance in treatment of mammary cancer in the future must be made largely in the line of earlier operation; and in order to this the family practitioner must more clearly grasp the meaning of the earliest signs of disease in the breast, and healthy women must be brought to know as a matter of general information and "woman's gossip," that skin-dimpling (even that which is not accompanied by lumps in the breast), is a danger signal which they will do well to bring to the notice of a surgeon.

The dissemination of such knowledge in the community is one of the duties which the medical profession owes to humanity.

### Correspondence.

#### PARIS LETTER.

PARIS, JAN. 8, 1892.

*Editor Maryland Medical Journal:*

DEAR SIR:—The New Year, with its accompanying good resolutions, makes one mindful of a promise I made you before starting on this trip in March of last year, namely, to write and let you know what is going on in medical circles in the old world. I have been in Vienna the whole time until the first part of December last, and will tell you something of things medical there. As to the advantages one has there for studying, it is generally supposed at home that if one wishes to learn anything at all in medical science, all one has to do is to go to Vienna. However true this may have been in years gone by, such is not the case, I am sorry to say, to-day. Now, what I am telling you about "general medicine" is only from hearsay, in a measure, but still from *very reliable* hearsay. There is not a good course to be had on gynæcology for love or money, although some acquaintances were foolish enough to pay a hundred guldens (\$40) apiece for a limited class of four. The same is said to be true, to a less degree, in the field of obstetrics. On "internal medicine" the only good courses are by Lorenz (Nothnagel's assistant) and Krauss (Köhler's assistant). This latter course is by far the best and is, indeed, *very* excellent; but the class is limited to four or six, and the men in this latter class keep him going all the time and renew their courses as fast as the previous one runs out. When there is a vacancy, however, it is filled by especial favor of the men already on the inside track. I would strongly advise anyone wishing to take up these aforesaid branches, or anatomy, histology, or chemistry, to avoid coming to Vienna, but choose rather Prague, Pesth, Munich, or some of the other smaller places. Now I do not wish it to be understood that this is a case of "sour grapes." I did not come here to take up these branches and made no attempt to do so, but am

merely telling you this in order that it may save intending students many disappointments. But now for those fields of which I can give a personal account. In throat work the place is only fair. The clinics of Prof. Ottokar Chiari, Dr. Hajék (Schnitzler's assistant) and Dr. Bergzaski (private clinic) are very good, especially the last two. Chiari is a splendid teacher but has very little material. But if you wish to get into their classes you should write fully three months in advance, for the same state of affairs exist here as in Krauss' class, namely, that they are limited to six, and the men once in, stay in, and only let their intimate friends know of a vacancy. I, for example, had my name down from June on, and hadn't a ghost of a chance to get into Bergzaski's class, even when I left. There were names down way back in April of men, who also had not succeeded in gaining admittance, so I am not the only one left. A friend of mine, since returned to Baltimore, can tell a like story. Prof. Schnitzler's is only fairly good. When I first got there, in April, it was very good, but latterly, Dr. Hajék, his assistant, fairly robbed the clinic of all the good material, until finally a party of Americans spoke about it to the chief. As matters did not mend, they left in disgust and refused to pay for what they had not received. Prof. Schrötter's clinic (now Prof. Störk's) is good. There is plenty of material and one sees more good cases here in one week than you would elsewhere see in three months; but this had again the drawback, that when you were getting well warmed to your work, some one would call out "Darf ich bitten, meine Herren," and looking around you saw the genial face of Professor Schrötter. To make the "Darf ich bitten" more sure, the lights are turned out and you must perforce, whether you will or whether you will not, go into the next room and hear a long harangue and some good old time "chestnuts" about a lot of antiquated instruments; finally, after wasting a lot of time, you are shown a modern instrument and hear about ten words on treatment. His last course, before giving up the throat department to Prof. Störk, was really very good, for it lengthened out into nearly three months, and having run the gamut of his old instruments, he really, towards the end, gave us excellent value for our time. As to ear work, Vienna still retains her lead, with such men as Gruber, Politzer and Urbantschitsch at the helm. After taking courses with all three you will find that you can get the best value from Dr. Miller, the assistant of both Gruber and Politzer, for notwithstanding their intense hatred for one another, they must be content with the one assistant.

And now for the climax. Surgery—well, I have only to mention the names of Albert and Billroth, with their host of splendid assistants, to assure you that you will find all that you are looking for in that direction. In eye surgery there is nothing which you cannot find. The clinic of Prof. Fuchs, in whose clinic I spent most of my time, offers every advantage for those looking for advanced work and able to talk German. You can see all the external eye diseases and ophthalmoscopic and refraction cases, and operations galore. Almost any day you see six or seven cataract and iridectomy operations and almost no end of strabismus and lid operations. After working here from eight in the morning til two or sometimes even three in the afternoon, you will think you have had quite enough. Courses on external diseases of the eye, refraction, ophthalmoscope and operations (on the cadaver) go to make the day's work more complete. Here I must say a word about Dr. Bergmeister's operative course, which is the very best to be had anywhere. Dr. B. makes every endeavor to bring himself in personal contact with his students, and one learns more from one of his courses than two of any body else's, yet the other men are really good instructors.

And now a few words about Paris. I am inclined to the belief that you can get better throat work here than at Vienna, with the additional advantage that everything is free, though within the past two years or so the younger men—well, they are not so young either—such as Messrs. Henri Chatéllier, M. Luc, A. Martin, Lubet-Barbon and others, have been giving courses of two month's duration each, and with the additional advantage that you can work, gratis, after the course is finished, which you cannot do in Vienna. These gentlemen all combine the ear and nose with the throat, so one has only to take the four or five courses and can then work on as long as one pleases. A very hearty welcome awaits any of our countrymen from these gentlemen, as they are anxious for the fact to be known that there is really good value to be had in this field in Paris. As to eye work, while it is good, and the men equally as cordial, still it is not to compare to Vienna. Firstly, one loses entirely too much time, and secondly, because you cannot see the patients as closely as is necessary for eye work.

Well, here I have rattled away until you will begin to think I am never going to cease; this is because I have no one to talk to to-night and I know no better way to have a good long talk than writing (?), because then, the other "feller" cannot talk back, and you have it all your own way.

With kindest regards to you and my medical friends, I am yours,

EDWARD J. BERNSTEIN.

### Medical Progress.

#### OUABAÏN.

This drug is a glucoside derived by crystallization from the juice of an East African plant used by the natives as an arrow poison. Dr. Sailer says of it in the *Therapeutic Gazette*, Dec., 1891:

My experiments show that ouabaïn in very dilute solution will produce corneal anæsthesia. No definite action was manifested on the pupil or intraocular tension. But a single experiment is not conclusive, and, owing to some change in the solution, four others that I performed were failures. Drs. Hare and De Schweinitz have experimented with strophanthin, and found that, although it produces complete corneal anæsthesia in dogs, it produces intense inflammation in the human eye. In view of this, it is obvious that in experimenting on the human eye with ouabaïn the most minute doses should be at first employed. I know of no reason, either histological or physiological, that would account for this great difference in the results obtained upon men and the lower animals.

A few points concerning the general action of the drug remain to be noticed. It is a powerful emetic, and acts as such when injected subcutaneously. This action it shares, I believe, with the majority of muscle depressants. It promotes defecation, perhaps, by increasing peristalsis. It is a diuretic; at least it seems always to cause urination in the animals to which it is administered. I can think of no reason, unless it be increased blood-pressure or paralysis of the sphincter. Lastly, it does not appear to affect body temperature.

This completes the account of my experiments with ouabaïn. Whether the drug will ever be of practical value, time alone can determine. Abroad it has already been employed with asserted good results in pertussis in doses ranging from  $\frac{1}{1000}$  to  $\frac{1}{300}$  of a grain. It would seem that very minute doses might have the same action as digitalis; but its greatest value will probably be found to exist in its power as a local anæsthetic, which is certainly superior to that of cocaine. For the present, we must be content to know that it is extremely poisonous.



## THE EUROPEAN PROFESSION AS SEEN THROUGH AMERICAN SPECTACLES.

Dr. Moyer, of Chicago, gives his opinions upon this subject in the *American Practitioner and News*, December 5, 1891, as follows:

1. The British medical profession is sharply divided into three classes, namely, physicians proper, pure surgeons, and general practitioners. The last named generally begins business by opening a drug store, with a little room in the rear which he calls the surgery. He employs a boy or qualified clerk to attend the store when he is engaged elsewhere. From fifty to sixty per cent. of American physicians "out West" own drug stores or are pecuniarily interested in them. I think that not more than five per cent. are similarly situated in Massachusetts.

In England physicians proper are only found in large cities; and most of them have the degree of M. D. Surgeons and general practitioners seldom take this degree. They are content with the plain title of Mr. Even such great lights as Erasmus Wilson and Thomas Spencer Wells had no medical title before being knighted; and the Queen has made the latter distinction so common that it has lost much of its charm.

2. No French physician or surgeon uses a medical sign to attract attention; and it is a rare thing to see even his name on the door. But British doctors nearly all use signs, and some of these are fully as prominent as ours. As a man rises in the profession, however, his sign becomes smaller, and sometimes entirely disappears.

3. Perhaps the most remarkable thing about the profession in Europe is the wide range of charges for attendance compared with our price-list. I knew a medical man in Belfast, Ireland, who accumulated a good-sized fortune at the rate of one shilling a visit. And I am acquainted with several experienced men of at least average ability, visiting their patients in a handsome carriage driven by a coachman in livery, whose medium charge is one shilling and sixpence. On the other hand, the upper and middle classes in Great Britain are charged higher fees than the corresponding ranks in Massachusetts. With us a wealthy man does not expect to pay much if any more than a clerk or mechanic does.

4. In England most prosperous practitioners employ one or two qualified assistants. I have sometime wondered why this custom has not obtained a foothold in the United States. The sale of an established practice is much more common in England than in America. It is also worth noting that the social status of medical practitioners is higher here than in Europe.

## AN EAR CASE.

In the *Amer. Pract. and News*, Dec. 5, 1891, Dr. Minor writes:

Mr. X. consulted me about his ears, January 13, 1888, and gave the following history: Age fifty-five years. Never heard well. In 1849 earache, and following this a discharge from each ear, which continued until 1870, when it yielded to treatment, but left deafness so great that only loudest tones of voice could be heard, and pencil and tablet had to be resorted to. This condition continued until 1880, when the hearing became worse and the discharge reappeared, and so remained until I saw him. I found absolute deafness in the right ear, the drum being retracted, thickened and scarred. In the left ear only the loudest sounds could be heard; the auditory canal was inflamed and covered with a membranous material of blackish color; there was a perforation about the size of a pin-head near the centre of the drum, from which pus from a suppurating middle ear escaped. My treatment was confined to this ear. The ear was cleansed by syringing with bichloride of mercury solution (1-5000), then dried with absorbent cotton, and tamponed with boric-acid powder. This procedure was repeated daily at first, and then at longer intervals, over a period

of about a month, at the end of which time all inflammatory symptoms subsided. The hole in the drum remained, however, and the hearing was as bad as ever, hence I decided to try an artificial drum. I first used the little rubber disc, so often tried and so rarely beneficial, but got no help from it. I then extemporized an artificial drum, by taking a bit of absorbent cotton and moulding it into a thin disc the size of the drum membrane. This was moistened with equal parts of glycerin and water and applied to the drum of the ear. As soon as it was properly placed there was an instant change in the facial expression of the patient, and he joyfully exclaimed that he could hear; that the noises from the street sounded again after a silence of eighteen years, and I was asked to speak, that the human voice might be heard naturally again. I did speak, and found that he could hear and understand when I spoke in an ordinary tone a few feet from him, but that elevation of the voice was necessary when I was further removed.

The patient has been under observation for nearly four years. He is still, to all intents and purposes, absolutely deaf except when an artificial drum is worn, but with it in place he hears well enough for all practical needs. The drum has to be changed every month or so. Occasionally the middle ear becomes inflamed, and the drum has to be removed while treatment for that affection is practiced.

The dark membranous material which came from the ear when treatment was begun I examined microscopically, and found that it contained a certain form of vegetable mold (*Aspergillus flavescens*), which sometimes gives rise to a very obstinate form of inflammation of the external auditory canal. In this instance it yielded to the treatment first instituted, and has not returned.

#### MEDICAL PROGRESS IN THE STATES.

In reviewing the progress of medicine during the past year, the editor of the *Boston Med. and Surg. Journal* notes the following advances in medical legislation:

Among the laws passed during the year, of interest to the medical profession, we may mention the following: The Immigration Law passed by the last Congress requires medical inspection of all immigrants on arrival. All idiots, insane people, paupers, or persons likely to become a public charge, or persons suffering from a loathsome, dangerous, contagious disease, as well as felons and assisted persons, are to be sent back to the country from which they came.

Congress has also passed an act establishing five stations for the inspection of meat which is destined to be exported. The principal duty of the inspector appears to be to hunt for trichinæ.

The State of Alabama has passed a law requiring all physicians who are not graduates of a reputable medical college to obtain a certificate of qualification from a board of medical examiners.

The State of Arkansas has passed a law allowing the Board of Medical Examiners, after trial, to revoke the license to practice of a physician, if convicted of unprofessional conduct.

The State of Nebraska has passed a law requiring a certificate from the State Board of Health and graduation from a legally chartered medical school or college, before a license to practice is allowed.

Among the States in which bills regulating the practice of medicine have been defeated, may be mentioned Massachusetts, Rhode Island and Pennsylvania. The latter State has already a registry law. Massachusetts is now one of five States only in which the practice of medicine is unrestricted by law.

The New York State medical practice law passed during the preceding year,

has gone into effect. It provides that no one shall practice medicine in the State without previously obtaining a license from the State Board of Medical Examiners.

In Massachusetts a law was passed requiring the detention of inmates of State penal and charitable institutions who are suffering from syphilis in a contagious form, until the disease is no longer contagious.

The State of Maine requires all persons having charge of an infant with sore eyes to report the fact to a physician. It has also passed a law to provide for the registration of vital statistics.

In Massachusetts an attempt was made to restrict the use of arsenic in the manufacture of various articles, but it resulted merely in prohibiting its use in children's toys and confectionery.

The United States Supreme Court has decided that a court may not order a medical examination of a person in a civil case against his or her will.

The Municipal Court of Boston has decided that a druggist may sell cigars on Sunday, as a drug to be used for the cure of catarrh.

RHUS AROMATICA IN ENURESIS.

The London correspondent of the *American Lancet* writes that Dr. Powel reports the cure of sixteen cases of enuresis by means of rhus aromatica and great attention to diet, etc. The cases had been treated unsuccessfully by other means. The treatment continued over a month. His formula is:

Extract rhus aromat	.	.	.	fl.	ʒ iij.
Elixir aromat	.	.	.	ʒ	iss.
Aq. cinnam	.	.	.	q. s. ad.	ʒ iij.

Mix. One and a half drachms, to be gradually increased to four drachms four times a day, after meals.

**Medical Items.**

There are some women of the brunette type, usually with an olive skin, sometimes with a fair skin, who have the misfortune to bear upon their upper lip or on the sides of their face, just in front of their ears, a growth of fine, dark hair. The hair is the lanugo variety and is noticeable only on account of its dark color. The application, by means of a camel's hair brush, of hydrogen peroxide will bleach the hairs and render them invisible except on very close inspection. As a preliminary measure it is well to wash the growth with a solution of powdered borax in water, to remove the grease which adheres to every hair. The application should be made several times a day until the hairs are thoroughly whitened, and after that as often as is necessary to maintain the color.

A remedy for "bumping" during the boiling of liquids advocated consists in placing a glass tube, about five to eight cm. in length and five to ten mm. in width (the exact dimensions depending upon the bulk of liquid to be boiled) and closed at the upper end, resting against the side of the flask or other vessel to be heated, so that it stands nearly vertical with its open, sharp-edged end pointing downward. Boiling goes on quietly when once started, the bubbles making their appearance at the lower end of the tube. On cooling, the liquid rises in the tube, which must therefore be raised and allowed to again become full of air before beginning the boiling again. The tube is best provided with a hook of platinum wire fixed in the upper end for ease of handling. The device is said to be efficient even for liquids containing heavy precipitates, such as barium sulphate and lead sulphate, and is also recommended for the Reichart-Volluy process,—*Amer. Druggist*.

Among the numberless cases of blood poisoning through the skin, one lately recorded is worthy of noting on account of its evident simplicity and the ease of its prevention. In the case referred to the sufferer was a seamstress, and the mischief resulted from her using a dirty metal thimble marked with verdigris, a little of which appears to have entered a scratch on the thimble finger. Verdigris, it is true, is a mere metallic irritant, and not comparable in virulence to most living germs of disease. It is quite enough, notwithstanding, to excite local inflammation, which friction, contact with dyed cloth material, or the entrance of dirt in any form, would quickly convert into a dangerous and general disorder. Steel thimbles are much safer and cost very little. Another variety also in common use is enamelled within, and is, if possible, even freer from objection. Cuts or scratches on the hand should never be neglected by sewing women so long as dyes continue to be used in cloth manufacture.

The site of the World's Columbian Exposition, in Chicago, is Jackson Park, lying on the shore of Lake Michigan, and containing something over 600 acres. Full advantage has been taken of this situation, and a broad esplanade, following the graceful curve of the shore, and a mile and a half in length, will form a delightful promenade, with beautiful vistas of the buildings and lagoon on the one hand, and on the other the blue waters of the lake stretching away to the horizon. The maintenance of the cleanliness of the beach and of the waters around the piers and casino—the latter built on the breakwater which protects the pleasure craft—has necessitated the construction of works for the treatment of the sewage of the Exposition. There will be in the main buildings toilet rooms and lavatories conveniently placed, containing a total of 2,000 water-closets with sufficient urinals and wash-basins. In addition, there will be toilet rooms with water-closets, etc., in the forty or more buildings of the States and Governments. Treatment of the sewage involves separation from the storm water, and as the site is flat, varying from seven to fifteen feet above Lake Michigan, any system of collection of sewage by gravitation sewers alone would necessitate very high grades; it has, therefore, been decided to pump all the sewage proper, and as the management realizes fully the necessity of using every means to secure cleanliness in every part of the grounds, which are each day to be occupied from twelve to sixteen hours by this very considerable population (150,000 to 400,000), they have selected the Shone hydro-pneumatic system of pumping as the apparatus best adapted for the work. Experience in Chicago has shown this apparatus to be cleanly, convenient, and trustworthy, and many of the city buildings rising to twenty stories which require large power plants for lighting, lift service, and heating, have of necessity the basement floors below the city sewers, and have for some years been perfectly served in the drainage of water-closets, kitchens, etc., in these basements by the Shone ejectors. The Construction Department of the Exposition, therefore, being familiar with the successful use of the ejectors, turned at once to them, and each of the large buildings is to be provided with two or four ejectors set in pairs under or adjacent to the buildings, so that excellent grades are obtained and the smaller buildings of the States and foreign governments, to which are devoted about 100 acres of ground, will drain to four ejector stations in each of which will be set two ejectors. The compressed air for the operation of the ejectors will be furnished from a central plant in the Machinery Hall, and the entire apparatus, consisting of about fifty ejectors, will be capable of discharging 8,000 gallons per minute.

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## CONTENTS

### ORIGINAL ARTICLES.

A Few Observations on the Treatment of Epidemic Influenza. By Alex. L. Hodgdon, M. D., of Baltimore. . . . . 331

The Treatment of Urethritis; with Special Reference to Oberlander's Endoscope. By A. Bradley Ganser, A. M., M. D., Baltimore. . . . . 333

Gunshot Wound, with Use of the Electric Probe. By A. K. Kirkpatrick, M. D., Philadelphia. . . . . 338

### EDITORIAL.

Stray Thoughts on Protracted Medical Education. 340  
Words of Cheer from Harvard Medical School. 341

REVIEWS, BOOKS AND PAMPHLETS. . . . . 342

### MEDICAL PROGRESS.

Gavage in Persistent Vomiting of Children.—  
Diphtherial Infection of Tracheotomy Wounds  
—Alopecia Areata. — Teucrium Scordium in  
Pruritus Ani.—Treatment of Rattle-Snake  
Bite with Permanganate of Potassium.—The  
Black Hair-Tongue.—Hypodermic Injection  
of Ether in Suspected Opium Poisoning.—The  
Etiology of Chaneroid.—Lawson Tait on Cor-  
pus luteum of Pregnancy.—Artificial Teeth  
from a Hygienic Point of View. . . . . 344

MEDICAL ITEMS. . . . . 351

## Original Articles.

### A FEW OBSERVATIONS ON THE TREATMENT OF EPIDEMIC INFLUENZA.

BY ALEX. L. HODGDON, M. D., OF BALTIMORE,

Member of the Medical and Chirurgical Faculty of Maryland. Fellow of the Virginia  
State Medical Society.

Epidemic influenza is not a new disease, but has been known for years and has received a multitude of names, the name most generally used of late years being the French term "la grippe." It is a disease which may be complicated by a host of other disorders, and in many cases the disease acts profoundly upon the nervous system. It would be useless to describe the characteristic symptoms of the disease which has been so universal for some time past, but I will only mention some of the drugs which I have used in this affection. The most prominent symptom which you have to combat on encountering a case of influenza, is the severe frontal headache, which is usually very distressing and seems to have a degree of concentration not present, as a rule, in other forms of headache. The patient sometimes suffers excruciating agony from this and the neuralgic pains throughout the body and limbs, and is extremely grateful when relieved of these. The best remedy that I have found for the headache and pains, especially when severe congestion of the brain co-exists, has been the following prescription, unless contra-indicated by pregnancy or cardiac disorder.

R̄.—Phenacetin (Bayer).

Salol, āā. grs., xxx.

Ergotin, (Sharp & Dohme's or Merck's) grs. xij.

M. Et divide in capsules xij. S. One capsule every three hours as directed.

I have given these capsules every hour for eight hours when the pain has been very acute. Next in efficiency for this trouble I consider the following formula.

R̄.—Morphiæ Sulph. . . . . gr. ʒ.

Sodii Bromidi. . . . . ʒj.

Fiat. pulv. j. S. One powder when required.

Or:

R̄.—Salol.

Phenacetin (Bayer) āā. grs., xxx.

M. Et divide in capsules xij. S. One capsule every three hours.

Great debility is an almost universal accompaniment of influenza, and nearly always when I find debility present I prescribe Reed & Carrick's liquid peptonoids in doses of one half tablespoonful every two hours. It is certainly a very palatable preparation, a patient of mine once remarking that the only objection he had to that medicine was that they did not give it to him often enough, as the taste was very agreeable. In the pneumonia of grippe I have given the liquid peptonoids as described above, with a glass of milk every two hours, and some wine whenever necessary, and for the cough accompanying this pneumonia, pure terebene, *mv*, on a little sugar every three hours. If it prove distasteful to the patients (most patients do not object to its flavor) it can be administered in an ordinary gelatine capsule. I know of nothing equal to this for facilitating expectoration in this trouble as well as in phthisis. For the severe colicky pains sometimes found in influenza, I consider the following good:

R̄.—Quiniæ Sulph. . . . . grs. xxx.

Morphiæ Sulph. . . . . gr. j.

M. Et divide in capsules iv. S. One capsule as often as required.

Also:

R̄.—Acid Hydrochloric. . . . . *m.* xxx.

Pepsin Pure (F. B. & F.) . . . . . grs. xij.

Glycerin. . . . . ʒiv.

Tinct. Cardamom Comp. . . . . ʒxij.

M. Et Sig. A teaspoonful in a glass  $\frac{1}{3}$  full of water every three hours.

During convalescence, I believe a generous diet should be partaken of and that a glass of beer with meals will prove useful. The following formula may be taken as a tonic:

R̄.—Quiniæ Sulph. . . . . ʒj.

Ferri Redact. . . . . grs. xv.

M. Et divide in capsules xv. S. One capsule three times a day when required.

It may be advisable in some cases to prescribe a good emulsion of cod liver oil for a limited period.

1235 Lafayette Ave.

Farnier, (*La Semaine Medicale*, 13, 1891), presented to the Academy of Medicine a pregnant woman with large irregular patches of pigmentation upon the chest, abdomen, back and hips, of an intensely brown color. The pigmentation began at the second month and increased steadily. Peculiarly enough these plaques were present during the first pregnancy to disappear a short time after delivery.—*Journal of Gynecology*.

THE TREATMENT OF URETHRITIS; WITH SPECIAL REFERENCE  
TO OBERLANDER'S ENDOSCOPE.†

BY A. BRADLEY GAITHER, A. M., M. D.,

Assistant in Genito-Urinary Surgery, Johns Hopkins Hospital Dispensary, Baltimore.

The claim that the pus corpuscles of a urethral discharge contain a gonococcus peculiar to themselves, to which specific urethritis is due, has been generally accepted, although some still hold that the gonococcus is the result and not the cause of the disease. If the cocci are found it is practically certain that the disease is specific urethritis, but if further proof is needed that the bacillus of Neisser is present, it can be obtained by the inoculation of pure cultures.

The best method for finding the bacillus is to first heat the slide to set the deposit, then add methylene blue solution, and wash off thoroughly in water. Under high power, and best with oil immersion, the bacilli will be found in the cells, or on the margins of the cells, often in great numbers. The bacilli diminish as the disease continues, and can only rarely be found in a gleet.

They exist mostly in the epithelial layer of the urethral mucous membrane, and some few are found in the sub-mucous layer. A suppurative inflammation is caused by the action of the gonococci in the mucous surface of the urethra, and the transformation of leucocytes and embryonal cells into pus corpuscles. The transmigration of cells, desquamation of epithelium, and the vascular congestion of the mucous membrane, are the same as in simple inflammation.

According to Bumm the organisms penetrate into the mucosa. This is followed by a migration of lymphatic cells which destroy the life of the organism. In this way the disease becomes self-limited.

The fact that urethritis often goes on to a favorable termination without any treatment is probably the reason that almost every remedy, old and new, is recommended for it. In the large clinics, however, where many cases are treated, we find the old drugs giving the best result.

From Neisser's clinic Dr. Friedham's report is complete and exhaustive. Many drugs were tried and a careful examination of the number of bacilli in the discharge made from time to time.

The injection of bichloride of mercury, 1-10,000 to 1-15,000, was used in 29 cases, in 14 of which treatment had to be stopped on account of bloody urine. In the second series with 1-20,000 bichloride of mercury no interruption in the treatment was necessary, but there was some pain. The anti-bacterial effect of the bichloride 1-30,000 was shown by the fact that the cocci disappeared in four days and after one week remained absent. In a weak solution this remedy acts only as an astringent, but in strong solution acts as a caustic, and only produces desquamation when inflammation enough has been set up to produce shedding of the whole layer of epithelium.

In another series of 29 cases salicylate of mercury was used, in strength 1-270, and 23 positive results of anti-bacterial power were obtained. Bismuth subnitrate and salicylate  $\frac{1}{2}$  to 10 per cent., 17 cases, six times decided influence on cocci. Permanganate of potash, 1-3,000 to 1-5,000, 17 cases, six results, but if used strong gives unpleasant irritative action. Salicylate of soda 5 to 20 per cent., 26 cases, five results. Antipyrine three to six per cent., 20 cases, three results. Naphthol 1-100 to 1,000, carbolized lime water 1-100, gave no marked result.

Zinc, lead and tannin had no anti-bacterial results, so we see that our popular prescriptions have no action on the cocci, but only act as astringents. Nitrate of

†Read before the Clinical Society of Maryland, November 6th, 1891,

silver has shown itself to be the best agent known for the treatment of urethritis. In 318 cases 237 showed marked bacterial results, and failure in the remaining 37 was attributed to inattention on the part of the dispensary patient.

Neisser uses injections of nitrate of silver, 1-400 to 1-1,200, four to six times daily at first, gradually diminishing them to one per day and continuing for several weeks after the discharge has stopped. During the first four days the discharge becomes richer, thicker and more purulent, but after that time becomes thinner, whiter, and contains more epithelium.

In 1200 cases, 22 cases of epididymitis developed under treatment, but only one where nitrate of silver was used.

Dr. G. W. Broome, of St. Louis, in a recent paper on "Gonorrhœa and its Rational Treatment," explains the action of the pathogenic bacteria as follows: In the first place, they abstract from the surrounding structures a part of their essential constituents; secondly, they produce the decomposition of albuminoid substances, from whence results the production of ammonia and its derivatives. This condition, together with the inability on the part of the inflamed urethra to expel all the urine voided from the bladder, and the chemical changes taking place in the retained urine, tends to macerate, as it were, the urethral mucous membrane. In consequence of this pathological process there results a thickening of the mucous membrane by infiltration into the sub-mucous tissue, which, if abundant, subsequently gives rise to cicatricial contraction and the formation of stricture. He concludes that urethral injections as heretofore used accomplished nothing more than to simply act as detergents to the urethral mucous membrane. In treatment he first uses a benzoic acid irrigation to the urethra and bladder for a few days, and bathes the penis in hot water. Then he applies five grs. of methyl-violet as a powder and states that besides exerting a definite and germicidal action it passes at once through the walls of the urethra, and penetrates completely all the tissues of the penile organ. He has observed no ill effects whatever to follow the application of the pure substance of methyl-violet. The treatment is essentially rational and has produced exceedingly satisfactory results.

Urethritis can undoubtedly be aborted in a certain number of cases if the treatment is begun at the first sign of the discharge. When the patient has just noticed an itching sensation at the meatus, and possibly a drop of pus is present, the case is a favorable one. If the lips of the meatus are swollen and everted, and the discharge is profuse, it is dangerous to attempt the abortive treatment. Injections of nitrate of silver, 1-20 to 1-40, should be used and care taken not to inject into the bladder. This will probably produce considerable pain on micturition. The next day a weaker solution should be used, 1-80 to 1-100, if the pain has not been great and the parts are not red or swollen.

A strong solution of nitrate of silver acts on the mucous membrane of the urethra in the same way that the cocci of urethritis act—causing death and superficial desquamation of the superficial epithelium. The efficacy of the treatment is due to the fact that the nitrate of silver acts much faster on the tissues than the virus, and consequently when the epithelium is broken down and thrown off, the cocci are destroyed at the same time.

The abortive treatment should never be tried if there is much pain, and only when there is great chance of success, as the risk of producing a stricture and making a serious complication to what might have been a mild case of urethritis must always be considered.

Urethral surgery has taken long strides since the discovery of the action of cocaine and the invention of the electric light. The pathological conditions of the



urethra have now been carefully differentiated and classified, so that an almost certain diagnosis can be made with the endoscope at once. Many endoscopes have been invented, but almost without exception the light is reflected into the urethra. Dr. Oberländer, of Dresden, Saxony, invented the endoscope which I show you to-night.

What are the special advantages of the Oberländer endoscope?

In the first place, it is the only one in the world which gives direct observation from a light burning free in the air at the point of inflammation. Secondly, it has a rheostat by means of which the light can be increased or diminished at will. Thirdly, the light can be used for the purpose of direct cauterization.

What are its main disadvantages?

Firstly, it is extremely complicated, and very liable to get out of order if not used carefully. Secondly, the most delicate parts must be sent to Dresden for repairs. Thirdly, the water apparatus requires the introduction of running water.

The problem to be solved in the invention of this endoscope was to cool the light which is introduced into the urethra.

If there should be heat in the urethra, of course moisture would be produced, which would obstruct the view. The cooling of the light is accomplished by means of a complicated water apparatus, consisting of capillary tubes, to carry the water down *behind* the light, and as the water is continually circulating, the light is kept perfectly cool, while its brilliancy is not affected at all. As the platinum light is very delicate, it is necessary to have as constant a battery as possible and to have a rheostat to control the current of electricity absolutely. By means of the endoscope all the changes of the mucous membrane can be recognized, such as change of color, over-fullness of blood-vessels, changes in the glands or epithelium, loss of elasticity of the walls of the urethra, etc., in fact, all that it is necessary to know.

Dr. Oberländer divides all cases into two great classes: First, Affections of the mucous membrane without marked participation of the glandular elements. Second, Those forms in which the glands of Littré play the important part.

In the first class the inflammation is diffuse, and does not result in localized contraction. It is sub-divided into two forms: (a) Urethritis mucosa hypertrophica. (b) Urethritis mucosa catarrhalis.

The first form is the more frequent, and comes usually eight to twelve weeks after infection. Viewed through the endoscope the mucous membrane is swollen, has a dull, velvety look, the long folds are no longer seen, and the affected portion bleeds freely on the introduction of a sound or cotton pledget. The openings of the lacunæ are deeply imbedded in the swollen mucous membrane; here and there a little secretion may be seen issuing from them. Such forms can heal without visible cicatrices.

The second form, urethritis catarrhalis, is much rarer and is characterized as follows: The mucous membrane is less swollen and elevated than in the preceding variety; it has a bluish, red, or spotted appearance, is more circumscribed, and small granulations can be seen covering spots the size of a pea, on which one can see slight erosions and epithelial proliferations. The lesions resemble chronic catarrh of the other mucous membranes.

The glandular division is sub-divided four times. It is not necessary to read descriptions of each variety, as only careful observation and long experience can enable one to make a correct diagnosis. I will read the description of one variety to show the difference between the mucous and glandular forms.

With "urethritis glandularis circumscripta," the endoscope gives the following picture: A circumscribed, almost round patch, half a centimeter to a centimeter in circumference, is seen on various portions of the pendulous urethra. The mucous membrane covering the folds projects somewhat into the canula and is paler and less shiny than its surroundings. At the centre, seldom at the periphery, one sees enlarged granular openings, which, according to the stage of the disease, may be deep red or show the remains of former hæmorrhages into the glands. These localized spots do not extend deeper than the thickness of the mucous membrane, etc. It must be remembered that in the normal condition of the urethra the glands of Littré cannot be seen.

These glands are inflamed and hypertrophied, and such inflammation is generally combined with peri-glandular infiltration; besides, they are generally affected in groups, leading to stricture formation. The inflammation may be confined to the mucous membrane or may extend deeper, involving the sub-mucous, and in fact all the structures of the urethra. It ends in the destruction of the invaded tissues, in the cicatricial formation, and the formation of true stricture. The endoscope can be used in all cases after six weeks, the urethra always having been irrigated with a boric acid solution before the introduction of the canula, which is size No. 25, French.

During the first five weeks the treatment should consist of irrigations of nitrate of silver, 1-1,000 to 1-5,000, four times a day. About a quart of the solution should be allowed to run into the urethra, the nozzle of the syphon never being pressed hard enough against the meatus to prevent a continuous return of the fluid. At the same time it is my custom to order capsule salol compound (Hynson & Westcott). One capsule three times a day. Each contains: salol, grs. iii; oleo-resin cubeb, grs. v; copaiba pura, gr. x; pepsin, gr. i.

Cubeb and copaiba seem to undergo changes in the economy by which they become germicidal. Appenheim has shown that urine passed by a patient after the administration of 20 grains of copaiba sterilized silk threads charged with microbes. Dreyfous used salol in large doses with the same end in view, and says that the treatment often aborts urethritis without danger. I have never seen any benefit result from the use of salol, and the only result has been to possibly make the urine darker in color. Many patients cannot use an irrigating apparatus at home on account of the size of the syphon, the bulk of fluid necessary, etc., so in these cases an injection must be given. In mild cases the following astringent injection may be found of use during the first two weeks:

℞.—Acid boric.	5ss.
Zinc sulph.	grs. iv.
Glycerine	ʒiii.
Aqua.	ʒiv.

Or it may be necessary, if the discharge is profuse, to start at once with a nitrate of silver injection, 1-2,000, gradually increasing the strength during two weeks up to 1-600 if it does not give pain. After the full strength has been used one week, gradually dilute back to 1-2,000, and continue the injection once a day for two weeks after all discharge has stopped. If there is much pain on micturition the following combination may be prescribed:

℞.—Potass. citrat.	ʒi.
Tinct. hyoscyami.	ʒ iii.
Aquæ.	ʒiv.

S. A dessertspoonful in water three times a day.

If the case shall have lasted more than six weeks; and after examination with

the endoscope it shall be found to be one without marked participation of the glandular elements, injections alone will constitute the treatment. Iodoform in oleum dulci amari, 4 to 10 per cent., will be found of especial value in cases where the mucous membrane has become flabby and very red, with a general loss of elasticity. It seems to act by lighting up an acute inflammation, which gradually subsides as the strength of the injection is decreased. It should be used once a day and retained in the urethra ten minutes. The instillation of a hot solution of nitrate of silver, 1-4,000 to 1-2,000, introduced as far back as the deep urethra by means of a catheter or instillator, will also be found useful in this chronic condition.

If the case is found to be one of the varieties of urethritis glandularis, dilatation will probably be necessary. Dr. Oberlander's dilators, which are modifications of Dr. Otis', are always used with a covering of rubber, which makes asepsis perfect, and also does away with the risk of catching a portion of the mucous membrane on withdrawing the instrument.

One drachm of a five per cent. solution of cocaine should be injected into the urethra, and rubbed in well, before an examination with the endoscope or a dilatation is made. I have never seen any unpleasant effects from the use of cocaine in this way and it generally gives satisfactory anæsthesia. Dilatations should be made at the intervals of eight to ten days, advancing from two to four numbers each time, up to 35 or 40 F. Careful observation with the endoscope should be made at each visit and the exact condition of the mucous membrane of the urethra noted. If the healing process is progressing satisfactorily, to dilate beyond 30 F. may not be necessary. The dilator should remain in the urethra five minutes.

At the beginning of the treatment it is usual to have some bleeding, as the urethra is brittle and stiff, but this condition soon passes off. The tears can be seen to be always through the affected portions, as in these regions the natural elasticity of the urethral walls is impaired or lost, and they must give way. During the treatment use a weak solution of nitrate of silver, 1-1,500, as an injection three times a day. It has an antiseptic, a cauterizing and a healing influence on the tears produced.

Do not examine the deep urethra if pathological conditions can be found in the pendulous portion to account for the symptoms.

If, on restoring the mucous membrane of the pendulous urethra, the gleet continues, then examine and treat the deep urethra according to the condition found present. Especial benefit may result from the use of deep urethral irrigations with a warm solution of nitrate of silver, 1-600, or an astringent injection of sulphate of copper, one per cent. If the mucous membrane remains sluggishly inflamed after treatment it may be necessary to inject into the deep urethra a few drops of a nitrate of silver solution, 1-20 to 1-5, but such strong solutions should be used very rarely, as they set up a considerable inflammation, and even when injected with the greatest care, often produce painful tenesmus. If, when the patient presents himself for treatment, a stricture is found, it is possible to dilate by means of Le For's dilators, if a filiform bougie can be introduced. Consequently, in almost all cases, dilatation will give a satisfactory result, with little or no risk to the patient and without confinement to bed.

Oberländer's endoscope stands alone in its ability to treat by means of direct cauterization with the electric light, a certain number of cases in which the discharge is kept up by chronic inflammation of widely separated glands of Littre. These are often the patients who come with the history "that after alcoholic or

sexual excesses they notice a slight discharge, which has always disappeared gradually, only to be lighted up again on the slightest provocation."

By inserting an especial platinum light it is possible to cauterize each minute gland separately, and as the burned surface does not extend over five millimeters, no stricture is produced.

It is impossible to cauterize too deeply, as the moment the light touches the mucous membrane the current is broken, and the light extinguished. By breaking the contact the light is re-established, and one sees how much has been cauterized and whether it is necessary to burn more deeply or not. If the condition is recognized, it is possible to cure at one visit a chronic case that would run on indefinitely under any other method of treatment.

17 E. Second St.

### GUNSHOT WOUND, WITH USE OF THE ELECTRIC PROBE.†

BY A. K. KIRKPATRICK, M. D.

Mr. S. came to my office at 3 A. M., October 2, 1891. He was stage manager for the Grand Opera Company, and is now dramatic teacher at the Penn Conservatory of Music. He returned from the theatre after attending to some business after the performance, and happened to think of a loaded revolver, and thought best to remove the cartridges, and believed he had removed the last one when his wife spoke to him, and his attention was drawn from the revolver a moment, and in that instant it went off, and he received the bullet, thirty-two calibre, in the leg above the knee. The muzzle of the revolver was not more than six inches distant, and the trowser leg was blackened and scorched.

Mrs. S. urged him to go at once to the doctor, and supported and assisted him to walk the three squares, and he was nearly exhausted by the time he reached my residence.

I gave him a stimulant and probed for the bullet, and thought I located it just above the patella on inner condyle of the left femur. The probing was very painful, and I was unable to get hold of the ball with the forceps, and I did not care to give an anæsthetic and go on with the operation without assistance, so I put him to bed and gave him a hypodermic of morphine and atropine, and he slept until 8 A. M.

I sent for Drs. W. H. and C. B. Warder, and for an electric bullet probe, which I had seen a day or two before. At 11 A. M. the doctors came, and Mr. Yarnall sent a man with the probe. Dr. Warder, Jr., etherized the patient, and Dr. Warder, Sr., enlarged wound and searched for the bullet carefully. He found a rough spot on the condyle, where apparently the bullet had struck and roughened the bone, and then been deflected and passed into the popliteal region, as the course of the bullet had been downward, forward and outward.

Mr. S. is a bicyclist, and has a fine muscular development—the wound being over two and one-half inches deep. We were about giving up the search when I felt what was apparently a spicula of bone, and to determine the fact passed the electric probe down along my finger, and with considerable difficulty placed it on the rough point. The alarm sounded, and we were convinced that the point was a corner of the bullet. I enlarged the wound and found it so. The bullet was buried in the bone, and the periosteum had closed over it, except a little corner as large as a pin-head, which had been turned up by the bone. We were not supplied with bone-chisel or gouge, and the bullet was below the surface of

†Read before the Philadelphia County Medical Society.

the bone, so forceps were of no use. I drew on the family tool chest for a gouge and the kitchen for the potato-masher, which I used as a mallet, and chiseled the bone away on one side so that I could pry the bullet out. We syringed out the wound with bichloride solution, 1 to 4,000, and Dr. Warder put in the sutures and a gum drainage tube, and covered the wound with iodoform gauze, and placed it in an improvised splint of trunk board.

The operation was long and tedious, and the patient did not regain consciousness until 3 P. M. He was too weak to remove from operating-chair until 9 P. M., at which time he walked to next room on crutches and went to bed.

In June he had suffered from functional disturbance of the heart from excessive smoking. He did not react well after the operation, and the heart was weak and irregular, so I gave hypodermics of strychnine and atropine, and inhalation of ammonia, and used hot-water bags. There was no vomiting. He had a temperature of 101° the evening of the operation, and 102° the next day. The third day 101°, and the fourth day normal. He required no anodyne whatever. The day after the operation I gave calomel, ipecac, and soda, followed by a Seidlitz powder, which moved the bowels freely. I also gave a five-grain powder of phenacetine every two hours until the temperature fell to normal.

The day after the operation I looked at the drainage-tube, and applied fresh gauze, and the second day syringed out the wound with bichloride solution, 1 to 4,000. The morning of the fifth day the stitches were removed, and their place supplied by narrow strips of plaster. The patient sat up the sixth day, and I took him home on the seventh day, and he has been walking around on crutches since. Yesterday was the eleventh day and he was at a rehearsal, and he expects to begin his usual work to-morrow evening. He kindly offered to come here to-night, and Mr. Yarnall is with us to exhibit the electric probe.

#### SALOL IN INFANTILE DIARRHŒA.

Dr. Weber says that salol manifests its antiseptic properties most markedly in infantile diarrhœa. It is this peculiar quality which renders it superior to many other remedies. Another advantage is the rapidity with which it acts, the vomiting and diarrhœa ceasing in twenty-four hours. Dr. Weber's formula is as follows:

R.—Salol . . . . . gr. iij.  
Tinct. opii . . . . . ℥ j.

M. Ft. tal. chart q. s. Sig. : One powder twice daily.

Of course the amount of laudanum and salol is to be adapted to the age of the patient, especial care being necessary in the use of the former.—*Gazette des Hôpitaux*.

#### INJECTIONS OF CAUSTIC POTASH IN EPITHELIOMA.

Professor Rossander of Stockholm has communicated to the Swedish Academy of Science a detailed account of some interesting observations on the treatment of epithelioma by injections of caustic potash around the tumor, by which four cases were stated to have been entirely cured. This amount of success, in his opinion, rendered it obligatory on him to report the matter to the Academy, but he is most anxious to avoid raising too great expectations of the general efficacy of this treatment in the present state of his observations.—*Lancet*.

## THE MARYLAND MEDICAL JOURNAL.

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.


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BALTIMORE, FEBRUARY 13, 1892.

Editorial.

## STRAY THOUGHTS ON PROTRACTED MEDICAL EDUCATION.

Medical education is certainly becoming more and more thorough, the civilized world over. In the period of this planet's history known as "the good old times," a man could cram most of the truths and the worst of the errors of "medical science" into his head in one or two sessions of a few months each. If his intellect was equal to the practical application of a few items of the former class, and his common sense revolted from the major portion of the latter, he made a reasonably safe physician in after-life. With mild cathartics, emetics, diet, and "cleaning out of the *primæ viæ*," he could not seriously interfere with the recuperative powers of nature.

After the introduction of the many-jointed names of modern science, and the addition of a host of deadly poisons to the materia medica, it was but natural that educators should take means to avoid the over-straining of the brains of the students, and should protect the public, by adding a year to the curriculum.

At the present time the introduction of bacteriological studies into the course of education for future family practice necessitates the lengthening of the period of training by a fourth year.

The English mind quails before the enormous mass of facts to be assimilated before beginning a career of medical practice, and so requires five years of preliminary study.

As science advances and new names of more intricate construction are added to the medical vocabulary, while "ologies" and organisms yet undreamed of are successively discovered, we may expect a corresponding increase of the years of preparation for practice. The vision of a sixth, seventh, eighth, ninth, and tenth year is unveiled before us. We may expect the graduate turned out from the ten-year school to be quite perfect in the diagnosis and treatment of the most obscure conditions of disease. Happy man! What a glorious career lies before him in his remaining years of life.

When we turn our attention to the pecuniary emoluments of the physician of the future we find that, according to the experience of the older and more populous nations of the world, competition and the increase in numbers of the "submerged tenth" (as General Booth puts it), and of the other tenths who are partly "submerged," may be expected to steadily reduce the incomes of the mass of medical practitioners, while the medical outfit of the physician ever grows in costliness.

Furthermore, it is at present a matter of common observation that the more scientific and the more literary a physician is at the beginning of his career, the less likely he is to devote himself to that humble study of the principles of business life and of the cranky side of his neighbors' characters, which is necessary to the building up of a well-paying practice (at least, outside of the specialties). While he sits in his office keeping up with the latest scientific advances and examining his patient's blood or faeces under an immersion lens, the doctor around the corner, who is considered by the initiated among his fellows to be an ignominium, is attending all the sick people within reach and waxing wealthy. There seems to be an "unevenness" somewhere.

If all the colleges require five years or more for graduation, then all their five-year graduates cannot be consultants; and unless human nature or the laws of competition change, most of them must get along on salaries which hardly support the present two-year graduate. Is the medical profession of the future to be composed exclusively of wealthy men and those whose fathers-in-law can be depended on for unearned office rent, or are the five-or-more-year colleges going to give free tuition? And yet higher education is undoubtedly a good thing.

Perhaps we may have, in the curriculum of the future, courses of instruction for students in the humoring of patients, the collection of fees, and some other like problems which assail the young practitioner.

The fact is, we ought to have different grades of practitioners of medicine, trained to different degrees of expertness and able to demand fees in proportion to the excellency of their graduation certificates. But, alas, the diploma doesn't either make or mark the excellence of the physician in respect to many essential qualities, which can be developed only amid the responsibilities of personal independent control of the sick.

The maturity of the student's mind should be taken into account in the preliminary examinations of a medical school. Men who have seen much of the world (self-made men), are likely to learn more of medicine in two, than inexperienced youths will learn in five, years. Men should be allowed, in schools of respectable curriculum, to graduate just as soon as they can show themselves possessed of the necessary knowledge and experience for beginning practice.

More moral integrity in the licensing bodies—that is what we need most of all.

#### WORDS OF CHEER FROM HARVARD MEDICAL SCHOOL.

We acknowledge with pleasure the receipt of a neat pamphlet containing the report of the first meeting of the Harvard Medical School Association; and take

the liberty of quoting a few paragraphs from the interesting addresses then delivered.

In the report of the Committee on the Harvard Medical School, Dr. Nichols offered the following impressive testimony to the advantages which accrue from endeavor after higher educational standards: "In 1872 the School radically changed its course of instruction from the old system of didactic lectures to a graded course, extending throughout the academic year, of three year's duration, in which the teacher comes into individual relations to the student, and of which laboratory and clinical work comprises a large and important part. A four year's course was at the same time provided for those who chose to pursue it. At the time this was looked upon by many as a doubtful experiment, and a somewhat hazardous one for a school whose teachers mainly depend upon tuition fees for their salaries. In the face of opposition and doubt, the Faculty has steadily pursued its course with such ability and devotion that success has come in full measure."

Among the advantages offered in the course of instruction which are worthy of imitation we note that "clinical conferences, both in medicine and surgery, are held, in which a student reports a case assigned to him for study, which is criticised by the teacher and by his fellow students. The students of the second class are allowed, in small sections, to assist as dressers in the surgical out-patient rooms of the Massachusetts General Hospital for a period of four weeks. One of the requirements of the examination in obstetrics is that the student shall have taken charge of and shall report upon six cases of labor. In the City Hospital the special wards for scarlet-fever and diphtheria offer unusual opportunities for the study of these diseases. There are post-graduate courses, offering the best advantages to those who wish to keep up with the progress of medical knowledge. Still pressing on to better things, the Faculty announces that after the next year a four year's course will be required as a condition to the degree of Doctor of Medicine from Harvard University." It is one of the objects of this Association of the graduates of Harvard Medical School to do all in its power to aid the Faculty in this new effort to elevate the standard of medical education and to compel the recognition of the American degree throughout the civilized world.

What is the Alumni Association of the University of Maryland's Medical School doing?

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### Reviews, Books and Pamphlets.

*Consumption*; How to prevent it and how to live with it. Its nature, its causes, its prevention, and the mode of life, climate, exercise, food and clothing necessary for its cure. By N. S. DAVIS JR., A. M., M. D., Professor of Principles and Practice of Medicine, Chicago Medical College. Author of a hand-book on "Diseases of the Lungs, Heart and Kidneys." F. A. Davis, Publisher, Philadelphia, 1891. Price 75 cents (net).



The purpose of the author in presenting this octavo volume to the public is briefly set forth in his preface. This purpose is to furnish to consumptives and to persons of a consumptive family, a plain statement of the hygienic rules which are necessary for its prevention, control or cure; and a clear idea of the nature of consumption, so that they may not be discouraged or deceived by the chronic and irregular course of the disease. The subject of climatic treatment is carefully discussed. The book is intended primarily for non-medical readers; but the physician will do well to peruse it. The tone of the author is hopeful, and we wish his work a wide circulation.

*The Principles of Bacteriology.* A Practical Manual for Students and Physicians.

By A. C. ABBOTT, M. D., First Assistant, Laboratory of Hygiene, University of Pennsylvania. With illustrations. Philadelphia, Lea Brothers & Co., 1892.

The first half of this octavo volume, which is presented as a text-book for students and practitioners, treats of the nature and laboratory culture of bacteria; the rest of the volume presents practical applications of bacteriology in medicine and hygiene. The observation of bacteria in air, water and soil; and the method for detection and study of the bacteria of septicæmia, tuberculosis, suppuration, typhoid-fever, anthrax and diphtheria, are carefully explained.

*The Diseases of the Mouth in Children. (Non-Surgical).* By F. FORCHHEIMER, M. D., Professor of Physiology and Clinical Diseases of Children, Medical College of Ohio. Philadelphia, J. B. Lippincott & Co., 1892. Price \$1.25.

We very heartily recommend this little book to every practising physician. He who carefully studies its very readable chapters will go forth to the observation and treatment of the oral and digestive troubles of his little patient with new enthusiasm and with much clearer views of the nature and symptoms of particular diseases between which he has to make a diagnosis than he would get by following the ordinary text-books. We do not believe in thoughtless book-buying; but the physician who purchases this volume will get the worth of his money.

*Saunders's Quiz-Compend, No. 23. Essentials of Medical Electricity.* By D. D.

STEWART, M. D., Demonstrator of Diseases of the Nervous System, Jefferson Medical College, Philadelphia; and E. S. LAWRENCE M. D., Assistant Demonstrator of Diseases of the Nervous System, Jefferson Medical College. Sixty-five illustrations. Price \$1. Philadelphia, W. B. Saunders, 913 Walnut St., 1892.

The first half of the book is devoted to the explanation of the different form of electricity and electricity-generators. The rest of the book treats of the principles and practice of the electrical treatment of nervous disorders; a few pages being given to an enumeration of the special surgical uses of the current.

Dr. Ferdinand King announces that having discontinued his connection with the *International Journal of Surgery* he has assumed the editorial and proprietary charge of *The Doctor's Weekly*. The second issue of this publication, a full-sized sheet of eight pages, is now before us. We shall watch with interest and good-will the future career of this latest medical weekly of New York City.

*Saunders's Question-Compend, No. 22. Essentials of Physics.* Arranged in the form of questions and answers, prepared especially for students of medicine by FRED. J. BROCKWAY, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. With 155 illustrations. Price \$1. (net). Philadelphia. W. B. Saunders, 913 Walnut St., 1892.

In this little book the author has endeavored to simplify the study of physics, which is not presented in concise enough form in the standard work of Ganot. An especial value is given to the book before us in that the author has drawn largely upon the teachings of Dr. Chandler in his lectures to the students of the College of Physicians and Surgeons, New York.

### Medical Progress.

#### GAVAGE IN PERSISTENT VOMITING OF CHILDREN.

In reporting twenty cases of irrigation of the stomach and introduction of liquid food by means of the stomach-tube, Dr. Kerley of the N. Y. Infant Asylum (*Archives of Pediatrics*, February, 1892), makes the following remarks:

A feature of great interest, which was brought out by the experiments, lies in the fact that, when but three or four drachms of diluted stimulants or light food could be taken by spoon and retained, three or four times this amount could be forced, not vomited, and the stomach found empty in two hours. This was most noticeable when the spoon or bottle feeding was alternated with the use of the tube. In two cases, in which everything was refused, food given in this manner was retained and digested.

It will be noticed also that the cases in which Gavage was most successful were those of low temperature, in which it did not rise above 103°.

To one who has not washed the infant's stomach many times this method of treatment may seem absurd, as it might be supposed that the tube would cause sufficient irritation or disturbance to produce violent retching and vomiting; but those who have practised washing of the stomach on a large scale, and done it properly, will recollect how difficult it is in many cases to make the child vomit, when, on account of thick mucus and large curds, this is desirable. In order to produce vomiting the stomach has to be crowded—filled to overflowing. In the N. Y. Infant Asylum, during the past three years, stomach washing has been performed not less than fifteen hundred times, and in comparatively few cases does vomiting spontaneously occur during the operation.

Gavage, if properly performed, disturbs the patient but little, and the success in some cases, especially those with very high temperature, certainly depends upon the dexterity with which it is performed. We have frequently introduced one ounce of food into the stomach in this manner—the duration of the whole operation being but fifteen seconds by the watch. In order to do it as rapidly as this, there must be no resistance on the part of the patient. Vomiting of small amounts during the withdrawal of the tube was troublesome in a few. This we found could be obviated to a great extent by *compressing the tube* during the withdrawal as soon as the funnel was emptied. This prevents the small quantity, which always remains in the tube, from escaping into the pharynx, or possibly into the larynx. In addition to this precaution, the tube must be withdrawn rapidly.

The writer thoroughly realizes that twenty cases are not enough to establish a point beyond all possibility of error, but the results obtained show that Gavage is likely to be serviceable:

1. In cases of persistent vomiting in infants, not of cerebral origin, after other methods have failed to relieve the patient.
2. Under any circumstances when infants can not, or will not, take sufficient nourishment.
3. Its application, like stomach washing, must be limited to infancy, since in

children over two years the resistance of patients make it almost impossible of application.

#### DIPHThERIAL INFECTION OF TRACHEOTOMY WOUNDS.

Dr. Spronk, of Utrecht, has discovered in the case of three children who had been tracheotomized for diphtheria a condition which has not hitherto been described, but which he thinks is far from rare. This consists in an inflammatory œdema of the subcutaneous and fatty tissue around the tracheotomy incision, caused by the invasion of diphtheria bacilli. He points out that in ordinary diphtheria the bacilli are confined to the epithelial surface and the false membrane, and never penetrate into even the uppermost layers of connective tissue so long as the mucous membrane is free from necrosis. Nor are the bacilli ever found in the internal organs and blood of infected individuals. Nevertheless it has been shown experimentally that these microbes can multiply in the subcutaneous tissues, especially of some animals, guinea-pigs for example. The cases he examined had died a few days after tracheotomy, and although the wound itself was free from membrane, and looked healthy, yet there was more or less widespread, diffuse œdema, without any change in the superjacent skin. This œdema was obviously inflammatory, but there was no necrosis. In two cases it occurred not only in the vicinity of the wound, round the trachea and in the intermuscular tissue, but extended for some distance over the chest and upwards to the supra-clavicular regions. He found by tube-cultures that the serum taken from different parts of the œdematous area contained abundant bacilli, which were almost as numerous at a distance from the wound as near it. The possibility that they may have multiplied after death was slight, seeing that these organisms require a temperature of at least 20°C. to grow. Other bacterial colonies were produced from the serum, but in one case this yielded almost a pure culture of Klebs' bacilli, and the capability of these organisms to cause this type of inflammation was proved experimentally. Dr. Spronk lays especial stress on the fact that, although of course the infection takes place through the tracheotomy wound, yet its margins appeared natural. This he ascribes to the use of iodoform and the short time that elapsed between the operation and death. The importance of the discovery lies in the additional risk of the rapid absorption of the toxine produced by the bacilli when these are lodged in connective tissue.—*Lancet*. (From *Centralblatt f. Path. u. Path. Anat.*, 1892.)

#### ALOPECIA AREATA.

In the *Jour. Cutan. and Genito-Urinary Dis.*, Feb., 1892, Dr. L. Duncan Bulkley writes in regard to this form of circumscribed baldness:

I am well aware, of course, that in many cases of alopecia areata spontaneous recovery will take place, even after repeated recurrences, and that we should be careful as to how we claim to cure a disease of whose causation we know so little. But the observation of several years, in a very considerable number of cases in private and public practice, has convinced myself and others that the method to be alluded to is certainly followed by satisfactory results, so that of late years I have applied it almost invariably, with the anticipation of much success. I will only add that, in advocating the treatment here described, it is only as a local measure, in place of other applications, and not at all to the exclusion of proper internal and dietetic measures, which I regard as necessary to overcome the condition giving rise to the alopecia areata.

The treatment to which it is desired to call attention is simply the very thorough application of pure carbolic acid, or rather, a 95 per cent. solution of

the same, well rubbed into the affected patches, one or more times, as will be described. I commonly employ a wooden toothpick, with cotton twisted on the end, making a small swab; this is dipped in the acid and, at first brushed lightly over the affected area, which is then afterwards well and firmly rubbed with the same for some seconds. I generally extend the application somewhat beyond the area actually bereft of hair, that is, when touching small separate spots. The application is a little painful at first, but I have never found patients to object to a second application when necessary. I seldom apply it to more than two or three square inches at a sitting, even when the disease is extensive; where there is a large area the surface is treated in successive portions, at intervals, perhaps, of some days.

The effect of the remedy is, as is well-known, to whiten and shrivel the skin, which, in a day or two, becomes slightly inflamed, and within a week or ten days the epidermis layer will exfoliate, leaving a reddened surface beneath. Occasionally there will be a little vesiculation, but among dozens of applications I have never seen anything which could in any way be regarded as a slough, and never such excoriations as are frequently found on other portions of the body from accidental or intentional application of strong carbolic acid. In my experience the tissue affected by alopecia areata on the scalp, at least, seems to present a different reaction, as regards this agent, from that found in normal skin. In my first employment of this remedy I proceeded with great caution, but now I rub vigorously with the little swab, without having ever seen cause for regret. I have not used this plan of treatment in alopecia areata of the bearded face or other portions of the body.

It is very commonly necessary to make more than one application of the acid to patches of alopecia areata, and I have generally allowed two weeks, sometimes longer, to elapse before treating again the affected patch; in a number of instances I have made but a single application, and at the expiration of two or three weeks a fine, downy fuzz could be seen, which increased into good hair.

In many of my cases this plan of treatment has been used in conjunction with other local measures, and also with internal and dietary treatment; but in a number of instances it has been employed solely and alone, for the purpose of demonstration. In the former there was always a marked difference in the growth of hair where the acid had been employed, and in the latter I have repeatedly demonstrated the growth of hair in tracts to which the application had been made, in contrast to those left untreated.

I have little to add in regard to the supposed *modus operandi* of the remedy. As is well known, I am no believer in the parasitic origin of alopecia areata, but from observation and analysis of cases I am the more confirmed in my belief in its neurotic origin. If pressed for a theory I should say that the profound impression made on the cutaneous nerves of the affected part by so strong and thorough an application as carbolic acid, in some way restored normal innervation to the affected area, even as we know that counter-irritation will relieve deep-seated pains in various regions.

I recognize also, in one sense, there is nothing absolutely new in the mode of treatment which I have here advocated, for it has long been the custom with many to blister patches of alopecia areata, and we have all probably seen the hair re-grow after stimulation thus produced. I would claim, however, that it is a cleanly, convenient, and effective mode of treatment, and one much less troublesome and alarming to the patient than ordinary blistering, and in my hands has proved far more successful than any of the milder methods with which I am familiar.

## TEUCRIUM SCORDIUM IN PRURITUS ANI.

In the *Therapeutic Gazette*, January 15, 1892, Dr. John H. Brinton, of Philadelphia, writes:

I have repeatedly employed this agent in the treatment of early hemorrhoids, accompanied by pruritus, occurring especially in young persons, and I am sure that I have found marked advantage from its use in cases when the usual treatment by lotions, ointments, and general measures has proved unsatisfactory.

This drug, *teucrium scordium*, is not a modern one, for its virtues as an anthelmintic were known as long ago as the time of Hoffman. The preparation I have made use of is the powdered leaf of the wild germandra, a plant of Southern Europe, the *Teucrium scordium*. The dose of the powder is 10 or 12 grains, suspended in water, taken three times a day, about half an hour before meals. The powder looks and tastes like a form of pepper, is an active stomachic, and stimulates the appetite. The effect of this drug, internally administered, I have found to be fairly satisfactory. In the cases referred to I have usually observed great relief to follow the exhibition for a week or ten days. At the expiration of this period the anal irritability and itching gradually decrease, and eventually disappear. With the alleviation of symptoms, the obnoxious habit of scratching is broken, and the patient ceases to be disturbed in his sleep. In more advanced cases of hemorrhoids, after the tumors have been fairly developed, I have not found that the drug exerts much influence. Its soothing and curative effect seems to be confined to the initial period of the disease and to the disturbed neurotic condition. How the remedy acts, I cannot tell. It would seem to be somewhat after the manner of Ward's paste, a rectal nostrum, probably of some pepper, famous in its day, and which has been spoken of, at some length, by Sir Benjamin Brodie, in his Clinical Lectures, and since by several rectal specialists. The *confectio piperis* (U. S. P.), was designed as a substitute for this paste, which is stated, in the U. S. Dispensatory, "to have acquired some reputation in Great Britain as a remedy in piles and ulcers of the rectum."

From an experience of some years, I believe that in the anal pruritus of the young, dependent on the causes mentioned, the *teucrium scordium* will be found of benefit. It is not, however, as specific for hemorrhoids, as has been claimed, nor does it, I think, influence the pruritus of any region except that of the anus. In pruritus vulvæ it is, I am sure, absolutely inert.

TREATMENT OF RATTLE-SNAKE BITE WITH  
PERMANGANATE OF POTASSIUM.

Having set forth at length his experiences upon this subject (based upon nine successful cases), Dr. Barber, of Wyoming, sums up (*Therapeutic Gazette*, January 15, 1892) his conclusions thus:

I would formulate the treatment for poison of the rattle-snake as follows;

1. Free incisions to the bottom of the wound and immediate cauterization: or, if this is not practicable, sucking of the wound.
2. The immediate application of an intermittent tourniquet,—that is, one which is relaxed for a moment at a time,—so that the poison may gain admission into the circulation in small doses.
3. The free administration of alcohol or carbonate of ammonium.

This might be termed the *urgency treatment* of snake-bite poisoning. The *curative treatment* requires,—

4. Free incisions into all portions of the inflamed tissues, and the thorough kneading into these incisions of a fifteen per cent. solution of permanganate of potassium

5. Multiple injections of the same solution into all the inflamed regions, but particularly into the region of the wound.

6. The complete surrounding of all the involved tissues, by permanganate of potassium injections placed from half an inch to an inch apart, the needle being driven into the healthy tissue just beyond the line of demarcation, and its point being carried to the deepest part of the border of the indurated area.

7. The permanganate of potassium solution should be used freely in fifteen per cent. solution. I have used one and a half drachms of the pure drug diluted and would not hesitate to use four times that quantity were it necessary, since it seems to exert no deleterious effect, either locally or generally.

8. The involved area should be dressed by means of lint saturated with fifteen per cent. permanganate of potassium solution. Stimulants should be given according to the indications,—*i. e.*, the condition of the pulse. Laxatives, diuretics and diaphoretics should be administered to aid in the elimination of the poison. The diet should be as nutritious as the stomach can digest.

#### THE BLACK HAIRY TONGUE.

In relating a case of this character (*Pacific Med. Jour.*, Jan., 1892) Dr. Montgomery gave the following facts concerning the disorder:

The filiform papillæ of the tongue arise by a large base, from the crown of which a number of small pointed papillæ spring, so forming groups, each seated on a common stalk. The epithelium of these papillæ, after covering the main trunk, runs up on each of the smaller papillæ like shingles on a steeple, and continues out beyond its apex, forming a delicate thread-like extension. The epithelium of these filiform papillæ is more resistant than that lining the rest of the oral cavity, and approaches in its nature the tough, horny epithelium of the skin. In some of the carnivora (cats) it even forms sharp, horny spines projecting backwards; every child knows the difference between the tongue of a cat and a dog. These epithelial projections are exceedingly variable in their length in different individuals, and even in the same individual, some being long and thread-like, others short and conical. Sometimes these epithelial cells become abnormally coherent, forming filaments even a centimeter and a half in length, constituting a thick furry covering, which has been frequently compared to a field of grain beaten down by a storm of wind and rain. In growing so long these filaments, which are at first yellow, become dark brown or even black from the large amount of keratine in the older cells, so constituting the dark color which has often attracted the attention of observers, and has given rise to the idea that the affection must necessarily be due to a parasite. This parasite was supposed to lodge between the long filaments, and to elaborate a black substance in the same way as the other pigment producing fungi, for instance, the *aspergillus niger*.

In order to apply the medicaments, the tongue must be well scraped with a sharp spoon. The papillæ are found rather prominent, but otherwise normal in appearance. The scrapings may be used for microscopical examination.

Each filament is made up of a great number of coherent flat epithelial cells arranged around an axis so as to overlap one another like tiles on a roof, the free edge being turned toward the base, just the reverse of hair, where the free edges project upward. The cells are not nearly so compactly set as in hair, the free edges projecting well out, giving the filament a ragged appearance. In the clefts between, there are lodged large numbers of bacteria, and micrococci such as one would expect to find in the oral cavity. The cells react to coloring agents like

keratinized epithelium, retaining very persistently the anilines, and staining an even red with alum-carmine, without any indication of a nucleus. The cause of the black color can be well seen under the microscope in the dark brown discoloration of the older cells, the aggregate giving a black. It requires a considerable amount of mechanical violence to tear a filament to pieces. Very often a number will be found united into a fasciculus, as if all those springing from the papillæ on a single crown had stuck together by their lateral surfaces. Many of the filaments are over a centimeter in length.

The diagnosis is not difficult. The presence of the long filaments is enough to differentiate it from the dark colored tongue occurring in phthisis. It is not caused by diabetes, for there is no sugar in the urine. The patient does not sleep with his mouth open, therefore it is not the dark tongue of mouth-breathers. He has not a high enough temperature to give him the dark tongue of fever, and he is taking neither as food nor medicine anything to give rise to the discoloration, such as red wine, tannic acid or iron. It is not the dark tongue which occurs in the dark-skinned races, and sometimes in Addison's disease, for he has a clear white complexion. And finally, we find frequently in syphilis an enlargement of the papillæ of the dorsum of the tongue, which sometimes assumes a dark color. The diagnosis from this last is easy when the pathological anatomy of the two conditions is borne in mind; in the syphilitic disease, the elevation is owing to an enlargement of the papillæ themselves, while in this affection the epithelial extensions are hypertrophied, and the papillæ, if enlarged at all, are of only secondary importance in producing the clinical picture.

The best method of treatment known is that of Geuzmer. The tongue is well cleared of the hairy mass with a sharp spoon, and the papillæ are cauterized with nitrate of silver. This will be of benefit even if does not work a cure.

#### HYPODERMIC INJECTION OF ETHER IN SUSPECTED OPIUM POISONING.

In the *Pacific Med. Jour.*, Jan., 1892, Dr. Dawson writes:

I was hastily summoned to a lady out of town. I found her in complete coma, with blue face, frothing at the mouth, conjunctiva completely insensible to touch, respiration about five per minute, body covered with perspiration, pulse rapid and weak, patient considered moribund. She had been in this state for several hours. I could get no history, but from the contraction of the pupils, suspected opium poisoning.

I began at once to inject hypodermics of brandy in the arm and sent to town for ether. I applied hot plates over the heart, had her arms and legs rubbed with dry mustard and bottles of hot water applied to the feet. When the ether arrived I injected a hypodermic syringeful in the arm. In a short time slight reaction was noticed. I waited about an hour, watching the effect on the pulse, and then gave a second injection of the ether. Consciousness soon returned and before I left the house, near midnight, the patient was out of danger and made a good recovery.

Several years ago I used the ether injection in two very bad cases, one of morphine and the other of alcoholic poisoning. The former was also in a state of complete coma, respirations about four or five per minute, appeared to be too far gone to recover, but after a few injections of ether, consciousness returned, speedily followed by recovery. The alcoholic case was also restored speedily by the same treatment.

The above may not be new to many of the profession, but no mention is made of it in the regular treatment laid down for such emergencies.

Ether is more than a mere heart stimulant. It seems to have marked deriva-

tive effects, and in seemingly fatal cases of opium poisoning it is more reliable, and acts more quickly in rousing the patient out of the fatal stupor than electricity, alcoholic stimulants, cold effusion, atropine injections, or any other known remedy.

Care should be taken that the needle be deeply inserted into the tissues, or sloughing of the skin may follow the injection.

#### THE ETIOLOGY OF CHANCROID.

At a recent session of the Genito-Urinary Section of the New York Academy of Medicine, Dr. R. W. Taylor (*Jour. Cutan. and Genito-Urinary Diseases*, February, 1892), stated that it is to-day generally believed that the chancroidal ulcer does not depend upon a specific virus of its own, and that while a chancroid may be and very commonly is derived from a previous chancroid, a chancroidal bubo or a chancroidal lymphangitis, it also may originate in pus derived from irritated lesions of syphilis and from irritated simple lesions in syphilitic subjects, and from various forms of simple pus, particularly when originating in active and intensely irritated lesions. De Luca and Ducrey have each claimed that they have isolated and cultivated a microbe which is the morbid agent in the production of chancroid, but their results are discordant and they failed to establish a clear scientific claim. The general sentiment among those who study bacteriology, Dr. Taylor said, is that the chancroid is the production of pus which contains the staphylococcus pyogenes albus and aureus, and perhaps the streptococcus. Chancroid is produced by pus rich in pyogenic microbes, and it is not safe to say to a man suffering from chancroids that the woman he cohabited with undoubtedly had chancroids. Dr. Taylor then gave the history of a number of cases coming under his observation in which chancroids had been derived from simple purulent vaginal secretions, and others, in which the chancroids had originated *de novo*; that is, in which they were due to some unknown source of contamination of herpetic vesicles; of chafes; abrasions or fissures.

#### LAWSON TAIT ON THE "CORPUS LUTEUM OF PREGNANCY."

Writing to the *Lancet* of Jan. 2, 1892, on this subject, Dr. Tait asserts with characteristic energy:

I am perfectly confident that I have made sections of more ovaries concerning the actual history of which the facts were known than any man alive. I have only to say that my conclusion long ago made, and confirmed by every investigation which I have made, is that the belief that the corpus luteum is altered in any way by pregnancy, or that there is such a thing as a true corpus luteum or a false corpus luteum in relation to the fact of pregnancy, is one of the most extraordinary crazes which has crept into medical belief, and it has been productive of a very large amount of mischief. It is one of those assertions which has been made in the early investigation of ovular physiology and pathology, based on the assumption that ovulation is a monthly occurrence, and it has been handed down from writer to writer without any kind of substantiating proof, whilst the negative evidence against it is perfectly overwhelming.

#### ARTIFICIAL TEETH FROM A HYGIENIC POINT OF VIEW.

It is common experience amongst dentists that a very large majority of artificial dentures worn are discolored and by no means devoid of unpleasant odor. This lack of cleanliness, which arises sometimes from neglect but often from want of instruction on the part of the dentist as to the necessary *modus operandi*, is a fruitful cause of inflammatory conditions. Debris of food mixed with saliva and mucous accumulating on a plate, rapidly undergo decomposition; with the



result of irritating the mucous membrane and producing a general inflammation of the oral cavity. The oral secretions become altered and vitiated, so as to cause dyspepsia, and caries of the remaining natural teeth is set up, which proceeds with great rapidity, especially in "clasp" dentures, not from friction, but because the inside of the clasps most generally escape the brush. The materials used in the construction of artificial dentures differ widely in their effect upon the tissues with which they come in contact. A larger number of cases of inflammation of the oral tissues occur where vulcanite is used as a basis than with gold or other metals, and so prevalent is this inflammation in the case of vulcanite that it has received the distinctive appellation of "rubber sore-mouth." Several reasons have been assigned for the effects produced by vulcanite. Nearly all this material is colored with mercuric sulphide (vermillion), which ingredient has been accused of being the cause of the trouble; but an exhaustive investigation did not substantiate this view, one particular point being that "rubber sore-mouth" often occurred where black rubber was used, which contains no vermillion. The porosity of vulcanite, especially when not sufficiently vulcanized, renders it liable to retain deleterious material if not kept scrupulously clean.—*Lancet.*

### Medical Items.

The United States Supreme Court has lately decided that a court has not the right in a civil case to order a medical examination of a person against his or her will.

Dr. William H. Norris, a prominent physician of East Baltimore, died suddenly Monday, February 8th. Further notice may be expected in our columns at an early date.

Sir Morell Mackenzie, the eminent English throat specialist, who, apart from his public fame, is well-known to the medical profession of the world through his literary works, died in London on February 3rd, of influenza.

The family of the late Dr. Frank Donaldson have given to the Johns Hopkins University his valuable collection of medical books, consisting of over eight hundred volumes. These have now been received by the Library and are being catalogued and arranged.

A gentleman in New York has just tested the result of preserving a turkey in a refrigerator for ten years. This time having elapsed, the fowl was removed from the refrigerator a short time ago, and after being properly cooked, was eaten by a party of well-known gentlemen. While putrefactive changes seem to have been entirely avoided, it was found that the meat was practically tasteless, and had lost all of its characteristic flavor.

Army and Navy officers, and particularly those of the medical branches, evince great interest in a contract which was awarded at the War Department for a new system of carrying medical and surgical supplies for an army in tablets. Ever since the last Sioux campaign, there has been a growing demand for a plan by which supplies needed by the surgeons could be placed in a more compact form than liquid and carried with greater safety and economy.

According to the *Chicago Tribune*, the pneumatic transmission of parcels is to be undertaken in that city. The Illinois Central Railroad Company has

granted the Pneumatic Transit Company the right to lay tubes along its roadbed from Randolph street to the World's Fair grounds. It is proposed to use tubes one foot in diameter, and the system is intended to comprise an application of electric switches to divert carriers to intermediate or way stations. It is expected to require a year to build the line, and a connection with the post office, for the despatching of mails, is projected.

The interesting intelligence has come to hand that the artificial manufacture of eggs is now an accomplished fact. Mr. James Storey, of Kansas City, has taken out a patent, and is said to be erecting a factory in view of doing a large business. Mr. Storey's ingredients are lime water, bullock's blood, milk, tallow, peas and a few other things, including some secret chemical preparations. The machinery for putting the egg together is very ingenious. First, the yolk is run into a mould to be properly shaped, and is then dumped into a second mould, which contains the right proportion of the preparation which stands for the white. This being a gelatinous substance, encases the yolk very readily. Then, by means of a special machine, the whole is covered with a shell, made of lime water and glue, which hardens after it is set. Mr. Storey guarantees his eggs to keep "new-laid" for a month, and he says that he can turn them out at a cost which will allow of their being retailed at the rate of three cents per dozen.—*Amer. Druggist.*

The champion tooth-drawer of the world is said to be a monk, Fra Orsenico, of Rome, who operates by the Japanese method—that is, with the simple instruments provided for him by Nature in the shape of his thumb and forefinger. His extractions average one hundred a day, but there are days (perhaps when an east wind is blowing) when the number does not fall short of four hundred. The good brother seems to be as proud of these dental trophies as an Indian brave of his scalps. He has two boxes containing thousands of more or less delapidated teeth from which he has delivered his patients; these are kept open in his operating room, doubtless *pour encourager les autres*. There seems to be some doubt as to who has the honor of having extracted the largest number of teeth at one sitting. An American dentist, Dr. Thomas Sneel, is said to have relieved a gentleman of 27 in five minutes, but a Plymouth doctor seems to have broken the record by extracting 31 at one fell swoop. He would, doubtless, have given an epic completeness to his work by drawing the thirty-second, but, unfortunately, Nature had been beforehand with him.

A remarkable case of maternal impression has lately turned up. It seems that a cow was quietly ruminating on the good dinner she had had, and thinking whether a supper would be equally as generous, when a deer ran suddenly into her lot, followed by a bear at his heels. There before her eyes the bear seized the deer and a short struggle ensued. The cow was in an "interesting condition." The awful sight riveted her to her tracks. Her fright was fearful to behold. Her eyes looked as large as "sacres"; her nostrils were distended; her tail assumed the horizontal position, and every muscle in her body twitched and jumped as though the current of an electric battery were coursing through them. The legs of the bear and deer were so mixed up in the struggle that the cow could not count them, or tell a hoof from a claw. She imagined that she saw a horn protruding from the forehead of the bear; and altogether the scene was very much mixed up in the mind of the cow. Her offspring was a frightful monstrosity, an exact reproduction of the image formed on her mind by the mixed and confused scene. Let no one hereafter doubt the fact of maternal impressions.—*St. Joseph Missouri Herald.*

# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

- Free Dispensaries; or, the Physician and the Poor. By Walter B. Platt, M. D., Baltimore. 353
- Some Contra Indications for the Use of Opiates. By Marie B. Werner, M. D., Philadelphia. . 356

### SOCIETY REPORTS.

- Clinical Society of Maryland. Stated Meeting held Jan. 15, 1892. Periodic Insanity Associated with Salpingitis of the Right Side. . 360

### EDITORIAL.

- The Physician and Opium-Giving. . . 363
- The United States Army Surgeon. . . 364

### CORRESPONDENCE.

- Treatment of Typhoid Fever by Baths. . . 365
- Professorship Vacant. . . 367

### MEDICAL PROGRESS.

- Dispensary Reform in England.—A New and Powerful Light.—Perforation in Gastric Ulcer.—Back Again to the Apprenticeship System.—Prescription for Bronchitis.—A Rare Form of Skin eruption.—Iodine in False Croup.—Vomiting in Pregnancy.—Malignant Syphilis.—The Detection of Tubercle Bacilli in Sputum. . 367

### MEDICAL ITEMS. . . . . 373

## Original Articles.

### FREE DISPENSARIES; OR, THE PHYSICIAN AND THE POOR.†

BY WALTER B. PLATT, M. D., OF BALTIMORE.

If one may be pardoned for a parody of the words of a well-known politician, and we trust the parody is more sincere than the pattern, let me say at the outset, "I am a dispensary physician." The sins of omission and commission of dispensary physicians in this and other large cities have raised a long-continued storm of denunciation, loud enough to drown the feeble sound of thanks which our best efforts sometimes call forth from the patients themselves. The sins against the true well-being of the community and the profession at large have in many cases justified all that has been said, and more.

The relations to each other of three classes of the community are involved, viz., dispensary patients, the profession, and the attending physicians and surgeons.

To do a proper work and truly benefit the patient the dispensary should treat only the impecunious and needy, and treat them only so long as they are without means to pay a physician.

The relations of these three classes must be so regulated that a free dispensary will be a blessing, and not a curse, to the physicians who live in the vicinity, as well as to those who go thither for treatment. And let me express my belief that nearly all in this city have been criminally negligent in treating almost all applicants without investigation.

Who, then, shall receive the services of a dispensary? Certainly only those who

†Read before the Clinical Society of Maryland, February 6th, 1892.

are very poor, and unable to pay even half an ordinary charge for a similar service. At the Garrett Dispensary I am in the habit of treating certain persons without question or doubt of their poverty. These are such as inhabit squalid alleys, whose denizens are well known to be universally poor. Not only their clothes, but their features, speech and motions, declare them to be ignorant, degenerate human beings, with a degree of viciousness and lack of moral sense because they are degenerate, sliding down the scale, approaching the human brute, with less than savage cleanliness, courage and foresight.

Such words as "Ignorance is the curse of God," should be painted upon the house-walls up and down our fetid alleys. Earning enough, with rigid economy, to live plainly and comfortably, they squander their little through ignorance of the first principles of right living, saving and spending. Their houses are often cold and damp from being poorly built, badly located and out of repair. This continually acting cause will certainly bring about a loss of earnings for days and weeks during a given year, to say nothing of the increased expenditure and demoralization consequent upon sickness.

The poor man knows no better than to rent such a house. No man cares for his body and soul sufficiently to say "Do not take this house; you or your children will surely be ill, and probably some of your family will die within a year or two if you rent it." No man or body of men rises up to say "He who rents a house he knows to be unfit for human habitation, and sure to cause disability, if not death, is worthy of fine and imprisonment." Surely, whoever inflicts sickness and suffering upon the ignorant poor is worthy of stripes well laid on. Yet there would be many smarting backs in the broad aisles of church and synagogue were such a righteous rule carried out. Who own these damp dens in Raborg St., Parrish and Vincent Alleys, in West Baltimore, or in Spring St., Dallas and Shuter St., in East Baltimore, or in a nameless host of others in the lower parts of the city? The public conscience must be quickened by the protests of physicians, until the politicians give our laboring people health before sickness, rather than a hospital after it.

What a mockery is the inalienable right to life, liberty and the pursuit of happiness when no man is likely to have a fair amount of healthy days for himself and family, who pays less than ten dollars a month house rent. I speak whereof I know, for I have been in these places, and had many conversations at the Garrett Dispensary with the poor, who in a large number of cases admit either that the house has no cellar at all, or that it or the wall of their habitations are damp. How often has every physician who comes into contact with the poor felt like saying, "What you need is not medicine, but a dry house, warm clothes and shoes, plenty of pure air, and properly prepared food," not to mention a frequent bath as a luxury beyond our fondest hopes. Without these things how important is medicine. Who in his senses would prescribe a remedy to improve the circulation while the patient had his feet in a snow drift! However, such cases form the bulk of dispensary patients, and are to be helped in one way or another where that is possible.

We can to some extent relieve their rheumatic pains, cure for the time their malaria, check their diarrhoea until the next attack, do something for their hearts, stomachs and kidneys, fire off their bowels, and, waving our mercurial wands, banish their syphilis. We can, moreover, open their abscesses, heal their sores, and bind up their wounds; beyond these things, little more. Ignorance and brutishness will soon bring about the same result in the future if the conditions of their lives remain as they are.

The physician who sees much of these people, views the efforts of kindly but

impracticable individuals, whose idea of help is to "give, give," as he would if they were beating the air in a vain endeavor to rise above the earth. Their misdirected energy adds fuel to the flame and makes the poor more helpless. They perpetuate instead of removing the causes of poverty. The mainsprings and relative importance as causes of poverty seem to me to be as follows: 1st. Ignorance first of all; they do not know how to live fairly well with the income they might earn. 2nd. Laziness and improvidence. 3rd. Intemperance, ill health, and licentiousness. 4th. A very small number whose condition is due to pure misfortune and not to one of the preceding.

If a free dispensary is so managed as to treat the very poor only, it will do the profession no injury; on the contrary, be a positive benefit by relieving them of the care of the class who tax their time and strength without yielding them any return.

Evidently the sticking point is, who are and who are not proper objects for free treatment? It should be as much the business of a well-conducted dispensary to diagnosticate poverty as disease, and always the first before the second. How is this to be done?

The ordinary way is by careful questioning, at the same time using the judgment that comes with a large acquaintance with the class in question, to determine how far their statements are to be believed. I usually ask: Are you able to pay a physician? What wages do you or the head of the house receive? Are you out of work? How many children are in the family? An ideal way is to employ in every case the efforts of a specially organized body whose business it is to find out just what we want to know, and abide by their decision, rendering aid without it only in urgent cases and until they can be heard from. I refer to the Charity Organization Society, who send a speedy and wonderfully accurate estimate of the ability of the family to pay, and whether or not they should be treated free of charge.

A good way would be to have a central bureau of medical relief, to whom the applicant should first go, and who should treat an urgent case without delay, referring them to the general dispensary nearest their homes for further treatment. All others should be carefully examined as to their ability to pay a physician in their own neighborhood. With the recommendation of this central office the patient might be treated at any dispensary for thirty days, when another permit could be issued, and so on.

To go to the central office twelve times a year for a recommendation is surely an easy way to receive medical treatment if such treatment is necessary. If, however, the patient is able to pay even a small fee to a physician, the dispensary and public opinion, instead of preventing him by any device, should compel him to make such payment as the most honorable of obligations. To give a man what he can by honest labor pay for, is to take the first and a long step toward making that man a blatant communist or beggar, who wants every man with more than himself to divide with "his laziness and improvidence."

While most of the ills that dispensary patients complain of are due to minor ailments preventable or curable by a little care, fresh air, and properly prepared and eaten food, there still remains a goodly number of organic diseases, readily overlooked in the hasty way dispensary patients are often examined. Many are the cases of cardiac valvular diseases treated for malaria, while there are doubtless scores of patients upon every dispensary record with undoubted renal disease who are treated for the accompanying dyspepsia, bronchitis or diarrhœa, but where no microscopic examination of the urine has been made.

Unless the dispensary physician is ever on his guard he tends to become brusque and arbitrary in his dealings with his patients, and hasty and superficial in his methods. I am inclined to believe that no one should hold a position of this kind too long.

Were I asked what ailments caused the majority of adults to seek treatment, I should say the following order represents them fairly, viz.: dyspepsia, constipation, malarial poisoning, bronchial and pulmonary diseases, venereal and skin diseases, and affections of the heart and kidneys.

At the Garrett Dispensary a record is kept of all who apply, in which is inscribed the history, physical signs, diagnosis and treatment. The number of old and new patients, white and colored, medicines, dressings and operations is easily and rapidly kept with poker chips of different colors, which are counted at the close of the hour.

An attempt to obtain medical advice by false pretenses of poverty should be treated as any other attempt to obtain value without rendering an equivalent. My own practice at present is, as nearly as possible, the following:

Inhabitants of certain squalid alleys well known to me are treated without question, their name, age and residence being recorded in a register. The destitute and forlorn, whose aspect is unmistakable to any one having dealings with the poor, come in first of all for treatment. Mechanics, artisans, or laborers, out of work and out of money, the poor families of drunken and worthless men, are in my opinion entitled to free treatment.

Adults who have to pay for their board and lodging out of their wages when the latter is less than \$5 per week, I usually treat free at the Garrett Dispensary. House servants, earning \$10 to 12 per month, can and do pay physicians for advice. I dwell on the pecuniary aspect of the case, since this is where the greatest care should be taken to prevent the pauperization of the patient, and to protect the practising physician.

When in doubt whether the patient, after all, is a fit subject for a dispensary, I have in very numerous instances referred the case to the Charity Organization Society, with most gratifying results. The writer would suggest that a conference of representatives of various dispensaries of Baltimore be held, to which a number of general practitioners living in their immediate neighborhood be invited, at which the entire matter might be thoroughly discussed, and a basis arranged upon which patients will be treated or refused treatment. Such an agreement should be signed by the dispensary physicians and be binding equally upon all. It then should be posted in a conspicuous place in each dispensary. Certainly it is time that something was done in our different cities to check what is already an injury to the public at large, and to the profession in general.

802 Cathedral St.

### SOME CONTRA-INDICATIONS FOR THE USE OF OPIATES.†

BY MARIE B. WERNER, M. D.

My object in presenting this subject before the Society to-night is manifold; I wish to show that in general practice the indications are limited for the use of opiates. We must fully realize that we have a broader basis for medical science than symptomatology, in order to give our patient the full benefit of our knowledge. Our position being at all times one of trust, we must endeavor, in helping our patient, to find the cause and remove it, rather than hide the symptoms

†Read before the Philadelphia County Medical Society, January 27, 1892.

it gives rise to by an opiate. Aside from the possible mental disturbance such a course of treatment might induce, it often materially complicates surgical efforts to relieve patients, the results of which we have repeatedly heard discussed at these meetings.

In order to discuss this drug with due fairness, it will be necessary to give a few moments to the consideration of its physiological action on the human economy. Dr. H. C. Wood, in his *Treatise on Therapeutics*, says: "When opium is taken in such a dose as to produce the mildest physiological effects, it exerts a quieting influence, inducing a peculiar dreamy condition; after a length of time, varying according to the idiosyncrasies of the patients and the dose of the drug, this condition passes into sleep, either light, dreamful, natural, or heavy and deepening into stupor. On awakening, the patient may return at once into normal condition, but very often he experiences a state of depression shown by languor, a little headache, nausea, or even vomiting, which may last for some hours. One of the most common of these departures from the ordinary course of symptoms is an excessive depression following the sleep produced by moderate doses of the medicine. This state is seen, as far as my experience goes, most usually in females of weak, nervous organization such as are peculiarly liable to attacks of neuralgia. The symptoms are a feeling of weakness and prostration, often accompanied by chilliness, dull headache and giddiness, but especially marked by intense nausea and frequent vomiting."

Bartholow states that, as a rule, opium does harm in all gastro-intestinal maladies in which there is a deficiency in the proper secretion, or a suspension of the functions of the liver and kidneys.

Dr. J. B. Mattison, in his valuable paper read before this Society in October, 1890, entitled "The Renal Status of Opium Habitues," after a careful analysis, arrived at the following conclusions: *First*, the habitual use of opium in any form will cause organic renal disease; *second*, the changes most likely to be met with are cirrhotic; *third*, that the rationale is threefold. Vasomotor changes: impaired general nutrition and inflammatory action due to non-eliminated irritant products. I would further call attention to the valuable contribution of Dr. A. Haig, published in the *British Medical Journal*, 1890, in his studies on the influence of opium and morphine on uric acid; also, of the retention of this latter product in the human economy and its relation to the causes of disease. His observations and experiments proved to him that the administration of opium or morphine caused retention of uric acid, accompanied by a reduction of arterial tension; that, when the effect passes off, there is a rebound, with an excessive excretion of uric acid and marked high tension, often accompanied by headache and mental depression.

Let us look carefully into these statements and compare them with our practical experience; we find that after lulling pain and induction of sleep, we come to a period of depression, even after a moderate dose of the drug. This depression is usually followed by a certain loss of resistance to bear any renewal of pain, and, in consequence, it becomes necessary to repeat the use of the drug; indeed, when we study carefully its action on a previously weak, nervous organization, we find the description given by Dr. Wood very ably describes the case for us. He tells us: "The symptoms are a feeling of weakness, prostration, chilliness, dull headache, nausea, etc." In the face of this the questions must certainly present themselves to us: Is it wise to simply gratify the desire of the patient? Would it not be better to study the cause and remove it rather than hide the symptoms which lead us to the origin of the trouble? I refer to cases

in every-day practice; cases in which a periodical monthly pain is lulled to sleep by several doses of morphine or opium, while the proper cause is left entirely out of sight. There is no doubt in my mind that cases have come to all of us where a case of chronic constipation or continuous indigestion, combined with a nervous irritable temperament, perhaps, added to that, or independent of this, an unpleasant skin eruption, etc., claimed our attention.

Quite often a question regarding any menstrual difficulties shows that there is some pain, often varying in severity, and the next question, What do you do for the pain? will elicit the answer: Oh! I take a little paregoric, or I have some pills or suppositories I use, perhaps previously given to some member of the family for pain. Not infrequently an investigation will show that the main ingredient is some opiate.

In our day of progressive medical science it becomes necessary that we should join hands and forces—first, to see if the proper hygienic rules regarding clothing, exercise and cleanliness are scrupulously carried out, and the proper functions of secretions and excretions are thoroughly understood. If aside from these precautions there is still pain, a local investigation should be made by the physician, and the condition carefully studied, the cause removed if possible. To give an opiate in such cases I consider criminal, since the patient receives a double injury; not only is she not relieved permanently, but she is robbed of much of her normal resistance, and I fear many have become chronic invalids, for it is a constant struggle to overcome the after-effects of the opiate before the time arrives for another relief of the same sort. If the patient escapes becoming addicted to the opium habit, she cannot escape the local gastro-intestinal irritation which is invariably set up, and which will defy all medication so long as its cause is kept up.

I can at this moment call to mind three cases, in which three weeks out of four all sorts of laxatives were used to overcome the amount of morphine taken during the fourth week; the complexion is sallow, the breath heavy, the skin impure, and how can it be otherwise? If an examination reveals no functional trouble other than the local congestion, or possibly some displacement downward induced by improper clothing or a lack of attention to the proper excretions, is it not at once clear that an opiate in the long run increases the cause of pain? Lulling the pain induces no cure, and the resulting constipation sets in two ways to make the patient worse; first, the pressure of a distended bowel; second, the absorption of effete products. Let such conditions continue for some years, as they often do, and we have other factors enter the field to make life miserable—sluggishly acting liver or kidneys, a worn-out stomach, and not infrequently a nervous wreck.

In order to emphasize this point, I will only have to call attention to a series of comparative experiments on animals† made by Dr. Edward Levinstein, and reported in his book on *Morbid Craving for Morphine*; his deductions from a number of experiments are as follows:

1. That internal applications of morphine sooner paralyze the digestive powers of the stomach than the subcutaneous injection.
2. Both ways of administering morphine bring on functional disorders of the secreting nerves.
3. Both cause catarrh of the stomach and intestinal tract.
4. Large doses of morphine given internally cause a subacute catarrh of the stomach, on account of the irritating chemical action of the morphine.

†. Covering a space of time from six days to five weeks.



5. The cutaneous injection of morphine causes a chronic catarrh of the intestines in a mechanical manner; in consequence of the impaired influence of the secreting glands due to the action of the morphine, the secretion of the digestive fluids is stopped altogether, or at least diminished in quantity, and consequently the intestinal tract is encumbered for a longer time by the ingesta.

The same author speaks of amenorrhœa and sterility as being a sequence to the continued use of morphine, drawing largely upon the results of his own observations, and accepts Pflueger's theory in explanation of it.

In these days, when "preventive medicine" is being advocated by all of us who desire to place medical science on the highest standard, should we not think many times more than twice before we write a prescription for an opiate to relieve pain? In the face of all these facts, it becomes a serious question of right and wrong if we stop short of exerting all our knowledge to study the *cause* of the pain we have been called in to alleviate. Often the prescription-book is entirely useless, unless its blanks could be filled with directions to the patient how to dress, eat, and give herself the physical care she needs.

The use of morphine after pelvic operations has been discarded by most of our operators, and clearly has been the means of reducing mortality rates as well as obviating many of the dreaded after-complications. I recall in one of my earlier operations the advice given by one of our older physicians to rely on opium and calomel, which I followed, with the result of having on my hands a sufferer from insomnia and chronic constipation after I had discontinued its use; had I not been careful to destroy all prescriptions, I feel certain I would have had more trouble. Another case comes to my mind of a patient who had a section done for some pelvic trouble by a physician, who also believed in the opium after-treatment. This patient came under my care later, and confessed that she had often helped herself to a suppository after the doctor had stopped their use. My object in referring to these cases is to show the danger of setting up the morbid craving and its attendant evils with only medicinal doses and in the space of two or three weeks; showing at once the danger a prescription containing an opiate may induce in the hands of a nervous patient who has periodical attacks of pain. Such cases do not always reach the state necessary to require hospital treatment, hence are often exceedingly vexing to the physician and surrounding friends. A direct accusation to the patient would often fail to bring the results desired, while the friends and relatives cannot always be relied upon for the tact and discretion so necessary. For that reason the physician must often exercise a vast amount of patience and time to educate the ones immediately concerned, and to prove the deleterious effects the use of opiates have, and then, *perhaps*, the patient can be cured.

It may, perhaps, be of interest to quote from a discussion on morphine in the British Gynæcological Society, 1889: Dr. Bantock gave as his experience after surgical operation "that patients were much better off without it—they escaped the restlessness which was left as the opium wore off. Dr. Bedford Fenwick called attention to the fact that opium increased the congestion of the kidneys to a dangerous extent, and might even go to a complete suppression of urine; also, that it caused a complete atony or paralysis of the muscular tissue of the intestines, thus preventing their acting. Dr. R. T. Smith had given two doses of a quarter-grain of morphine each in a case of severe shingles; the patient had suppression of urine for twenty-four hours. Dr. Thomas Savage, in his address read at the annual meeting of the Birmingham and Midland Counties Branch of the British Medical Association, says: "It is not long since it was the cus-

tom to administer opium and morphine as a routine treatment in all cases of peritonitis and many other conditions in the abdomen. We have now learned the inadvisability of so doing. May we not extend the withholding of these and similar drugs in other states? I have myself thought that the general practitioners rely too much upon anodynes."

In this matter of too sympathetic and assiduous medical treatment errors rather of judgment than intention are often committed.

Of no less importance is the behavior of an opiate on a patient of uric acid diathesis, in which a demand for relief of pain on the part of the patient often becomes quite urgent. Here again the researches of Dr. A. Haig show us that the drug tends to store up the acid; that when elimination begins to take place there is often a return of pain, the patient again demanding relief—in this manner a cycle can easily become established. These pictures teach us the importance of keeping the drug *entirely out of the reach of the patient*, and the necessity of its *careful and conscientious* use where it may be indicated.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JAN. 15, 1892.

The 260th regular meeting, held in Baltimore, Vice-President R. B. Norment in the chair.

*Dr. L. McLane Tiffany* read a paper entitled SKIN DIMPLING IN CARCINOMA OF THE FEMALE MAMMA. (See JOURNAL, Feb. 6, 1892.)

*Dr. George J. Preston* read a paper on "Hæmorrhage into the Substance of the Spinal Cord, with Report of a Probable Case."

*Dr. Harry Friedenwald* reported several cases of "Atropine Intoxication from the use of Eye-drops."

*Dr. R. M. Hall* related a case of PERIODIC INSANITY ASSOCIATED WITH SALPINGITIS of the right side, and asked about the advisability of removing the uterine appendages for relief of the mental trouble. Patient has had three attacks, one of which is now on her. They occur about the 11th or 12th of the month. Menstruation occurs at the first of the month. All that now remains of the salpingitis is an enlargement in the right side.

*Dr. W. S. Gardner*: Although the attacks may not come on at the time of menstruation, yet the two things may be related. If these attacks come on every four weeks and the woman has her menstrual period regularly, there is a relation of time, if nothing else, and it is possible that by careful watching a connection could be established between them.

*Dr. J. F. Martenet*: All physicians, and especially gynæcologists, recognize that a condition may be developed about the uterus and its appendages which can excite acute mania. I do not arise to answer Dr. Hall's question, but to relate a case in my own practice. I attended the woman in confinement. Her husband confided to me that she was a very willful woman and had had two attacks of acute mania, each associated with child-birth. During this confinement no symptoms of mental trouble appeared. On recovery, she went on a visit to the South, her husband remaining at home. On her return some months later she was in a nervous condition, and finding some things at home not to her liking she became worse. I saw her on Friday; by Sunday she was in a state of acute mania.

*Dr. Rohé*, of the State Insane Asylum: I believe the mental trouble to be due to uterine excitement and suggest the removal of the ovaries. I am inclined to think it would be better to postpone the operation for a time. The woman should bear no more children.

*Dr. J. E. Michael*: I think it is admitted by those who have given the subject attention, that the insanity in women due to the puerperal state, pregnancy and disease of the genital apparatus is a condition which develops in persons predisposed to insanity by inheritance. A case came under my care last summer of a very intelligent young lady who was married under rather unfavorable circumstances—a good deal of excitement attending the wedding. The groom took his bride to his home in Virginia. In one week from the time of the marriage he brought her back perfectly insane. Her family had heard of the removal of ovaries for the cure of insanity and suggested this treatment. I opposed it because I did not think it an operation which ought to be considered under the circumstances. Previous insanity in the family was denied, but upon careful investigation I found that this young lady had suffered previously from insanity, lasting several months; also that an uncle had been insane for a number of years; her father also had several attacks of insanity. I regarded it as hereditary insanity, the exciting cause being the excitement attending the marriage. I suggested an asylum, and was dismissed. Doctor Wilson got the case and I was able to follow its course. In three months the symptoms gradually cleared away. I think there is great probability that insanity will again develop.

In *Dr. Hall's* case there was salpingitis in which the acute symptoms have passed away and there is some residuum of the inflammation. The woman has become insane. Her uncle has been insane. She evidently has a predisposition to insanity and this particular condition has been the exciting cause. I am very much inclined to the view that if this woman had been subjected to oöphorectomy or any other excitement that insanity would have been the result. I do not think the operation is indicated in this case more than in the case of any other exciting cause. I think the operation is decidedly contraindicated.

The data given by *Dr. Hall* do not seem to show a definite relation to the menstrual flow. The case is to be regarded simply as one of insanity.

*Dr. J. H. Branham*: *Dr. Michael*, judging from the two cases related, seems to be opposed to operation for mental trouble. There is no question but that there are some cases in which benefit is derived from such operation. On the other hand, there are doubtless a great many cases that would be made worse. I know of a case in which mental trouble developed in a young woman which was thought to be associated with some abnormal condition of the uterine appendages. Their removal was effected and the woman developed violent mania just after the operation, and she died in this condition.

If cases are clearly associated with abnormal conditions about the uterus, especially attacks of melancholia occurring near the menstrual period, it seems, from the report of many cases, that great benefit is sometimes derived from these operations.

As to the case in point, there is not enough information before the Society to decide whether there is any relation between the menstrual flow and attacks of insanity. Cases of acute salpingitis tend to recover very often if let alone, but frequently the apparent recovery is only a period of relief, and without any other infection, from some exciting cause, such as overwork, the trouble recurs and operation may have to be done. In *Dr. Hall's* case I think it would be better to wait and see if the mental symptoms cannot be cured without operation. Certainly an operation should not be done within three months.

*Dr. G. J. Preston:* I think the point that Dr. Michael partly brought out, viz., the careful consideration of the personal and family history of the patient, is most important. There may have been certain things in the life of the individual which may have caused the insanity, such as a period of trouble, emotional excitement, great poverty, or some other decided shock. Where the family history shows distinct heredity, I perfectly agree with Dr. Michael that there should as a rule be no attempt to cure by operation. The relationship between the higher brain centres and the genital organs is very close, and irritation of one may cause disturbance in the other. Some of these cases pointing to uterine irritation amount simply to hysterical mania. I have seen two or three cases that were relieved temporarily by hypnotism. I saw one in Charcot's clinic suffering with violent mania who was perfectly rational the next day after being hypnotized. Since then I have run across cases now and then in which the hysterical symptoms amounted almost to mania; these symptoms would subside at certain times and were closely related to some genital disturbance.

Where there is no distinct hereditary predisposition and where there is in the patient's personal history the evidences of decided genital irritation, and there is a chance of this irritation still continuing, it would seem to me that an operation would promise the best results. Cases of recurrent mania are among the most obstinate of all forms of mental diseases. If an operation would hold out any hope, I should be in favor of advising it and particularly early in the case. An operation later may do no good; just as in epilepsy, an early operation may do good while a later one may not. As there is in the case under discussion some genital irritation persisting, and the attacks of insanity are periodic, I should be strongly in favor of the operation.

*Dr. Michael,* replying to the remarks of Dr. Branham, said: I did not mean to go into the discussion of operating in cases where there is distinctly a relation between menstruation and the mental condition. I did not deem it a part of the present discussion. I should not hesitate to perform laparotomy in cases where these things exist.

*Dr. W. G. Townsend* related a case which was under his observation for about three weeks. A young lady, aged about 23, had hysterical attacks periodically, and finally was the subject of acute mania. She had marked tenderness in the right ovarian region. She has been placed in an asylum and her ovaries removed. The result of the operation was not yet known to Dr. Townsend, but would be ascertained and reported to Dr. Hall.

*Dr. Hall:* The tumor in the lady's side does not seem to trouble her at all. I would like to ask if there are any cases on record where perfect recovery ensued after operation.

*Dr. Preston:* There are a certain number of such cases on record in which operation have cured the mental symptoms. The operation has not been as successful as was hoped for, perhaps because it has been performed rather indiscriminately; but there are undoubted cases which have resulted very favorably.

1603 N. Broadway.

WM. T. WATSON, Secretary.

#### FARADIZATION IN INCONTINENCE OF URINE.

We read in the *Archives of Gynecology* that Dr. James reports a case of incontinence in a girl aged fifteen, where internal medication had failed of any result, in which a complete cure was obtained by faradization of the urethra—the negative pole in the urethra, and the positive on the thigh.

**THE MARYLAND MEDICAL JOURNAL.**

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A. K. BOND, M. D., Editor.

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BALTIMORE, FEBRUARY 20, 1892.

**Editorial.****THE PHYSICIAN AND OPIUM-GIVING.**

We read with pleasure in advance-sheets of a recent discussion of this subject in the Philadelphia County Medical Society, occasioned by two articles read before it on the therapy of opium; one of which appears in this issue of the JOURNAL, the other being deferred to a later number. The physicians and surgeons taking part in the discussion differed on many points, but seemed to yield silent assent to repeated assertions that medical men are responsible for many cases (some claim for cases), of the opium habit in the community. One speaker declared as the result of personal investigations "the ordinary prescription-file of the drug stores will show that three out of five of the prescriptions contain opium in some form or other." This statement is a surprise to us and we could not accept it without further evidence (at least as being true of all cities).

It is worthy of remark that the sense of the society seemed strongly in favor of the view that the physician, in prescribing opium, ought to guard against this evil by concealing from his patients the name and nature of the drug ordered. This we earnestly contend can best be done if he furnishes the opiate himself in the form of tablets. The only alternative is that he should hand the prescription to the nurse and charge her to conceal its ingredients from the patient. The liquid preparations of opium will probably continue to be ordered by prescription and the nurse must be relied on for secrecy. Solid opium, and especially morphia, can readily be carried in tablet form and given without prescription.

Those physicians are very culpable (and there are many of them), who tell their patients, especially nervous individuals, the name of every drug administered, or who order them to go to the drug store and get a prescription for morphia pills filled.

The deodorized tincture of opium is not easily recognized by the uninitiated either by its taste or by its name as an equivalent for laudanum, and codeia may

in some cases be used instead of opium as a remedy for slight pains and for nervousness.

The physician who makes the concealment of the name of his drugs (especially anodynes and nervine agents), a rule of medical life will have many disputes with women who have learned from former doctors the whole round of nervous drugs, but he will as a rule be all the more respected for his stand. With such patients the physician needs to put on a little mystery in order to better command their obedience.

The thought that not one life has been cursed by him through careless prescribing of opiates will be a sufficient reward for the extra trouble of carrying a few tablets in his satchel or concealing the nature of the drug from his patients.

#### THE UNITED STATES ARMY SURGEON.

Believing that it will interest many of our readers we introduce some paragraphs from a circular sent us by the Surgeon General:

The Medical Department of the Army consists of one Surgeon-General with the rank of Brigadier-General; one Assistant Surgeon-General, and Chief Medical Purveyor and four Surgeons with the rank of Colonel; two Assistant Medical Purveyors and eight Surgeons with the rank of Lieutenant-Colonel; fifty Surgeons with the rank of Major; and one hundred and twenty-five Assistant Surgeons with the rank of First Lieutenant of Cavalry for the first five years of service, and of Captain of Cavalry subsequently until their promotion by seniority to a majority.

The salary of each grade is a fixed annual sum, payable monthly; but at the end of each period of five years of service the annual sum representing the pay of the grade is increased by ten per cent. until forty per cent. is added. After twenty years of service the forty per cent. additional continues to be drawn, but the further increase of the pay by ten per cent. additions ceases; *i. e.*, an officer, although he may have served twenty-five or thirty or more years can, under existing laws, have no more than forty per cent. added to his pay proper by way of increase for length of service. The pay of a first lieutenant of cavalry, or of a medical officer during the first five years of his service is \$1,600 per year, or \$133.33 per month. At the expiration of his five years of service he becomes, by virtue of that fact, a captain with a pay of \$183 monthly. At the end of his tenth year of service his pay is increased to \$200 a month. After twenty years service he begins to receive \$233 a month; if promoted at this time (as is usual), \$291 a month. Subsequent promotion may raise it to \$458 a month. Increase in salary is associated with promotion in rank up to that of Brigadier-General. Compulsory retirement at the age of sixty-four increases the rapidity of promotion for young men. The surgeon retired by age, or by accident in service before he reaches his 64th year, draws 75 per cent. of the salary held by him at time of retirement. When stationed in cities which have no Government quarters the medical officer receives commutation money to cover house rent. The Government pays his expenses when he is traveling under orders.

The authorized leave of absence accorded him is thirty days annually. This leave is not forfeited if not taken during the year, but is credited to the officer, who may thus accumulate a continuous leave of four months on full pay. If he desires to be absent for a longer period than four months, and the permission is accorded him, he is reduced to half pay for all time in excess of the four months or maximum of cumulated leaves of absence. Absence from duty on account of sickness does not affect the relations of the officer with the paymaster; he continues to draw full pay.

A commission in the Medical Department of the Army is an instrument which is good for life, premising conduct consistent with its retention on the part of its possessor; but it involves no contract which binds the individual to service for any given number of years. On the contrary, should the medical officer find on experience that civil life has greater attraction for him than that of the Army, there is nothing to prevent him from at any time tendering the resignation of his commission.

A young medical officer on appointment is usually assigned to duty for a few months at some large post where there are other officers of his department, to afford him opportunity of becoming acquainted with the requirements of the Army Regulations and the routine duties of military life. After this he goes to some post west of the Mississippi river, where he serves a tour of duty of four years. An assignment in the east follows the leave of absence which is usually taken at this time; and in after years his stations are selected so as to give him a fair share of service at what may be called desirable posts as an offset to the time spent at less desirable stations.

Candidates for appointment to the Medical Corps should apply to the Secretary of War for an invitation to appear before the Army Medical Board of Examiners. (See notice in column of "items" in this issue). Candidates must be between 21 and 28 years of age and graduates of a regular medical college, evidence of which, the diploma, must be submitted to the Board of Examiners. His physical condition must be shown by examinations to be good.

*At the present time there are 15 vacancies to be filled.*

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### Correspondence.

#### TREATMENT OF TYPHOID FEVER BY BATHS.

*Editor Maryland Medical Journal:*

Thanks for your review in the JOURNAL of January 23rd, 1892, of my book on "The Hydriatic Treatment of Typhoid Fever According to Brand, Tripier and Bouveret and Vogl.\*"

I further take the liberty of sending you some passages from a letter of Dr. Brand. He writes "In the *Semaine Médicale*, November 4th, 1891, there is a communication by Roque-Weill, entitled 'de l'élimination des produits toxiques dans le fièvre typhoïde suivant les diverses méthodes de traitement.'

\*E. E. Sibley, agent, 916 Edmondson Ave., Baltimore.

The lines of treatment compared are: (1) the Brand method; (2) the antipyrin method after Clement (0.5 antipyrin every three hours); (3) the nihilistic. With the Brand method the urotoxic coefficient is 5-6 times as great as in the normal condition, to become normal with the setting in of apyrexia. With the method of Clement the elimination is = to 0. After convalescence a sudden (brusque) excretion of five to seven days' duration sets in. With the nihilistic method the coefficient is double that of the normal; the excretion, however, is incomplete, and sometimes for four to five weeks after the fever has gone down."

I make this communication because one point in the effect of the baths has not been mentioned by you, and that is the effect on the urinary secretion. When the method is carried out correctly the patients pass enormous quantities of pale urine. Now, this may be of a good deal of importance, and if here the French observers have not made a mistake it would seem as though with the Brand method the noxious materials were washed out of the system just as quickly as they are formed. I think Brand, perhaps, is right when he says that the method is a whole—if one link is taken out it becomes unreliable. The drinking of large quantities of water is, however, part of it.

Further, you speak about "partial collapse, which should be disregarded." I must protest against the notion that the condition of the patient during the last minutes of the bath is anything like collapse. His heart contracts more energetically, and his *appearance* is simply due to the powerful contraction of the organic muscles of the blood-vessels and skin, and my private belief is that this effect will at some time later on make the beneficial actions of the baths more clear to us than is the case now. The difference between this condition and collapse is as great as between day and night.

Although I first adopted the method on account of the statistics, I have continued it on account of the good effects which I have personally observed upon the condition of the patient, which no article of the *materia medica* is able to bring about, a fact which the second chapter of my book discusses.

Miss L., mentioned on page 325, who had to take over 130 baths, certainly had a severe attack. She lost just *three pounds* during her illness. Of course, then she took and *digested* as much nourishment as when she was well. She certainly belonged to the class of "delicate people" who are imagined to be unfavorable subjects for the bath. It is just the other way—the weak and delicate people are doubly in need of this line of treatment, which is supporting and refreshing *only*, and not at all depressing.

I cannot admit that I have seen anything that was alarming using the baths. Never have I been called on account of a mishap with the 2,000 cool baths that have been given. That a quarter grain of morphine has produced alarming (to the patient) symptoms has happened to me since using the Brand method; but that a bath has done the same has not yet occurred to me. I admit that they are unpleasant; quinine is bitter (I would rather take a bath); the taking of ether and its after-effects certainly must be very unpleasant. Yet, that on that account they ought not to be employed, I have not yet heard stated. However, the baths have even their very pleasant side. Thus my last case was a very mild one, of a lady who had been under medical treatment for over a week. She had not had any sleep of the kind she wanted. Three baths a day made her perfectly comfortable, and she enjoyed sound, healthful sleep. She often said "she liked the baths" and always greeted me warmly at my visits. I expect that in a few years my patients will demand the baths.

I feel sorry that I was not thoroughly informed in regard to this method of treat-



ment when I began to practice my profession. I would therefore say to you, "Dear Doctor: Have three bath-tubs made, and use them, and in a few years you will think as much of them as of any article in the materia medica. You will feel that you have acquired new powers for doing good."

As far as expense to the patient is concerned, connected with the method: If the physician furnishes the tub, as he ought to, and as I do, and if the friends of the patient do their own nursing, the expense ought to be less than that of ordinary methods, because very little medicine is used. If they employ a nurse, one that you will have trained, why then the physician need to make fewer visits and the family gets a good deal more for the money if it goes to the nurse than to the doctor. In this case a nurse would have been employed anyhow. What we need for success is the early reporting of the patient's illness, and further, that they take an interest in this line of treatment. I think that after a family physician is convinced that he is doing a wrong not to use the method, the family will feel this and follow the advice quick enough.

Truly yours, C. SIHLER.

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### PROFESSORSHIP VACANT.

CHICAGO, ILL., Feb. 8th, 1892.

*Editor Maryland Medical Journal:*

A Concourse will be held at Rush Medical College, Chicago, beginning Tuesday evening, March 1st, for the purpose of filling the positions of Lecturers on Anatomy, and on Materia Medica and Therapeutics in the spring Faculty. The spring course begins March 31st, directly after the close of the regular term, and continues two months, with a class of from 250 to 300 students, thus affording the lecturers an excellent opportunity to exercise their skill as teachers.

It is the policy of the College, so far as practicable, to fill vacancies in the regular Faculty from the corps of spring instructors. Nine of the present members of the regular Faculty have been elected in this way. The concourse will consist of twenty minute lectures by each of the applicants, before the Faculty, students and local profession, upon subjects pertaining to their branches, which will be furnished by the Professors of Anatomy and Materia Medica and Therapeutics a week before the contest.

832 Scranton Ave., Cleveland, O.

E. FLETCHER INGALS, Registrar.

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### Medical Progress.

#### DISPENSARY REFORM IN ENGLAND.

As akin to the original article presented to our readers from the pen of Dr. Platt, we may quote the following from the *British Medical Journal*, January 9, 1892:

No system has yet been devised which, depending for its success on the good feeling or the moral sense of the masses, has as yet fully achieved its object. The Great Northern Hospital system has been so framed as to be for the most part independent of the moral obliquity of individuals. It consists essentially of a system of inquiry into the circumstances of all applicants for relief and the refusal of all who exceed a definite wage limit laid down by the hospital authorities. All cases are further made to pass through the hands of a qualified casualty officer, who is required to be a resident in the neighborhood of the hospital;

and by him the trivial cases are separated from the cases of real disease or injury. No case is refused first aid, but all cases refused further treatment under the wage limit are offered a form of certificate which, if they can get signed by their own doctors, entitles them at their next visit to be registered as regular out-patients. The working of the scheme is controlled by a mixed medical and lay sub-committee, who are responsible for all the acts of the inquiry and casualty officers. In any case of doubt as to the truth of a patient's statements the sub-committee are empowered to institute inquiries at the patients' own homes. The objects of the Great Northern Hospital Committee have thus been threefold. While protecting the funds of the hospital from misapplication, they have also borne in mind the interests of the local practitioners, and have further rendered the labors of their own honorary medical officers less onerous and more effective by their system of preliminary medical inspection. The patients themselves receive treatment in accordance with their requirements, and although the scheme may be objectionable in the eyes of the few upon whom it operates, it would appear to be popular with those whom it protects. It is worthy of note that a form of voluntary pay system was for a long time in vogue at the Great Northern Hospital, and that it failed signally to check the ordinary forms of abuse. The practitioners in the neighborhood of the hospital rose up in arms against it and at the instance of their own medical officers the committee withdrew it. Pay systems as established at Guy's Hospital, the Queen's Hospital, Birmingham, and elsewhere, whether accompanied by inquiry or whether put on the same footing as at the provident dispensaries, are, and must be, liable to abuse. Rigid and regulated inquiry would seem to be the only effective means of detecting such abuse, but unless universally adopted will only have the effect of driving unscrupulous persons from one institution to another. Combined action, as attempted among certain of the Manchester medical charities, or by the agency of the Charity Organization Society, would probably prove the most economical method, but it is open to question whether the more effective results would not be obtained if every hospital protected its own interests as the Great Northern Hospital has done.

#### A NEW AND POWERFUL LIGHT.

A very intense light, such as is required for photographic or occasionally for medical purposes, may, as is well known, be readily obtained by burning magnesium ribbon, which has, however, the disadvantage of being somewhat expensive. An excellent substitute has been found by a French chemist, M. Villon, in aluminium, which is about a third of the price of magnesium, and which may be utilized in the same manner by burning it in a spirit lamp, or, if a flame of much more intense brilliancy is required, in a coal, gas, or spirit flame supplied with a jet of oxygen. In these it burns without emitting fumes, in which respect it is superior to magnesium. The light given by aluminium has a high actinic power—nearly as high, indeed, as that of magnesium. The most convenient way of obtaining a very intense light, according to M. Villon, is to use a lamp provided with a jet of oxygen at the centre of its flame, into which powdered aluminium mixed with a quarter of its weight of lycopodium and a twentieth of its weight of nitrate of ammonium can be projected by means of a tube furnished with an air ball. This gives an exceedingly intense light, without smoke. A mixture of aluminium powder with chlorate of potash and sugar can be ignited, giving an intense light by means of gun-cotton, but is somewhat dangerous. Probably the best plan for medical photography, or for laryngoscopic and auroscopic and other demonstrations, would be to burn a ribbon of aluminium in an

ordinary spirit lamp. Of course, if oxygen and an oxy-hydrogen, or a oxy-alcoholic, lamp were at hand a much more intense light could be obtained.—*Lancet*, January 2, 1892.

ABDOMINAL SECTION FOR PERFORATION  
BY GASTRIC ULCER.

In the *British Medical Journal*, Jan. 9, 1892, Drs. Simon and Barling report a case of operation for this cause and refer to another already reported. They add the following remarks: In commenting upon the two cases, though both of them ended in death, we still do not hesitate to urge the necessity for operation for perforated gastric ulcer. If left without operation, death in from one to two days follows in a large majority of cases; of the minority, nearly all die in a few days or weeks from mischief extending into the abdomen or thorax, or from a secondary perforation. Relief by operation has hitherto been rarely attempted; but once the possibility of this has been realized by the physician and surgeon alike, and operation is resorted to early after the perforation has occurred, it appears to us that success in a proportion of cases ought to follow.

From the literature of gastric ulcer, it is difficult to determine accurately the commonest position of ulcers which perforate. Although a very large proportion of ulcers are situated on the posterior wall of the stomach, yet actual perforation of these is quite frequently prevented by the presence of adhesion to adjacent organs, especially the left lobe of the liver and the pancreas; whilst ulcers on the anterior walls of the stomach, though relatively few in number, have a much greater tendency to perforate, owing to the absence of adhesions. This question of the position of the perforation is, however, for our purpose, not a matter of great importance, as in any case abdominal section is called for. If, when this is performed, the leaking point cannot be discovered, or from its position cannot be closed by suture, the evacuation of the escaped contents of the stomach should be effected, and, after flushing, a drainage tube inserted, and by prolonged rest of the stomach time gained for adhesions to close the perforation. If, on the contrary, the perforation is in an accessible situation, it should be carefully sutured, though the patience and dexterity of the surgeon may be taxed considerably to effect this.

The presence of a considerable quantity of fluid in the lower part of the abdomen and the pelvis in our second case, suggests the wisdom, when a widely spread peritonitis exists, of making an opening just above the pubes for the sake of draining there as well as at the site of the operation.

Cases of perforation naturally range themselves into two classes, each of which is typified in our two patients. In the one there is the immediate severe collapse, with severe pain, vomiting, and the outset of a rapidly spreading severe peritonitis, these conditions being due to a free escape of stomach contents, often induced by some exertion on the part of the patient. In these cases, given a previous history of gastric ulcer, the diagnosis is not obscure, and the indications for operation are clear. In the other class, of which our second case is an example, there is more difficulty in making a diagnosis of perforation. Here we have pain, sickness and faintness, with slowly extending tenderness and distention, but all these conditions are much less marked in the early stage than they are in the first group, though they may at the end of two or three days develop rapidly, and end the patient's life in a few hours. Here there is a smaller leakage which becomes more or less encysted by adhesions, and which may eventually form a well-defined abscess, perforating into the intestine, or on the surface of the abdomen, or into the thorax; or some accidental exertion, such as that of vomiting,

may rupture the collection into the general peritoneal cavity, and set up a rapidly fatal diffuse peritonitis. In this second group, ill-marked as the symptoms are as compared with those in group one, yet with a history of symptoms of gastric ulcer they would generally call for an exploratory incision.

#### BACK AGAIN TO THE APPRENTICESHIP SYSTEM.

In addressing a British medical society, Dr. Orlando Jones (*Brit. Med. Jour.*, Jan. 9, 1892), in suggesting improvements in the public standing of the medical profession says: In the first place, I think that the tone of the profession might be raised by the introduction of a law enforcing at least one year's apprenticeship before the commencement of the ordinary course, during which time the compounding of drugs and other preliminary work could be studied, which would be of great benefit to the profession in various ways.

#### PRESCRIPTION FOR BRONCHITIS.

For cases of acute bronchitis with "tight" breathing Dr. Engle advises the application of from sixteen to twenty-four dry cups, and the administration of the following mixture:

℞.—Tartar emetic . . . . .	6 grains.
Spirit of Mindererus . . . . .	3 ounces.
Fluid extract of glycyrrhiza . . . . .	6 drachms.
Compound glycyrrhiza mixture (filtered) sufficient to make . . . . .	9 ounces.

Two teaspoonfuls of this in half a glassful of water should be taken every two hours, the meals being so arranged that they fall half way between two doses of the medicine — *Medical Summary*, June, 1890.

#### A RARE FORM OF SKIN ERUPTION.

Dr. Kenwood reports (*Lancet*, Jan. 9): An interesting case of an aberrant form of urticaria has been under my supervision for some years, and it serves to sustain in a striking manner the now generally accepted theory that this disorder is due primarily to a direct or reflex irritation of the peripheral vaso-motor system, in which contraction, followed by a partial paralytic dilatation of the cutaneous vessels, determines the exudation of lymph with the production of wheals. It must be held, however, that each sufferer from the complaint possesses a hyper-sensitive condition of the vaso-motor system, so that more or less trivial causes will suffice to disturb its balance. A severe body-chill has always furnished the exciting cause in this case, and after careful and thorough investigations the most absolute negative evidence of any concomitant derangement, either of the digestive, nervous, or reproductive systems, has been forthcoming. The urine has however, always had its color and acidity somewhat accentuated, but there has been no albuminuria or lithuria. The patient, who is now twenty-five, first noticed "swellings" when between seventeen and eighteen years of age, and they have since recurred on almost every occasion upon which she has caught a violent chill. She has always enjoyed excellent health and is of a slightly florid complexion. The eruption mainly consists of wheals, which are sometimes six inches in diameter, and are generally discovered on the third day after the chill (that is to say, when the other effects of "the cold" have somewhat spent themselves). These may occur anywhere about the body; the lips and eyelids (especially the lower) are frequently attacked, and the pharynx is said to have been involved on an occasion during which I did not see her. Over the area on which a wheal is about to form the following sequence of events has been invariably noticed by both the patient and myself. The area at first suddenly assumes a slight red

blush, sometimes bright like erythema, but generally of a somewhat dusker hue, and at this stage a faint "tingling" pain manifests itself. When the spot is rubbed by the patient or myself—and in all other cases the necessary friction or pressure is doubtless given by clothes, etc.—the centre rises, becomes blanched (relatively), and then extends rapidly by an indefinite border until it reaches the limits of its extension, by which time a faint red line is seen to surround a paler swelling. The tingling sensation is at all times slight, is greatest in the stage immediately preceding the swelling, and then diminishes, to disappear entirely when the wheal has reached its maximum development. At this later stage there are no subjective sensations of any kind which would tell her of their presence so long as she remains at rest, and does not rub or press them. The swellings last in bad attacks two days; but they have come and gone in two hours, leaving in no case any trace whatever of their existence, and we have both succeeded in some cases, but only early in the attacks, in producing wheals by friction over areas which have appeared perfectly normal. Apart from the slight discomfort accompanying "the cold," the patient feels perfectly well and in good spirits.

There have been present, in *most* attacks, œdematous tumefactions of the skin and subjacent tissue, of firm and knobby consistence, with ill-defined borders, and possessing a slightly pale hue relatively to the adjacent skin; which tumours pit (almost imperceptibly, it is so slight), upon pressure. Their favourite sites are the skin over the deltoid muscle of the arm and that over the region of the buttocks. The swelling of the tongue which accompanied a recent attack was due to one of them. They have never been, in any case which I have had the opportunity of investigating personally, less than two inches and a half in their longest diameter, and have generally shown a tendency to assume an oval shape. The largest had a diameter of over six inches, and was situated upon the buttocks with its centre over the tuber ischii. Their near relation to the urticarial wheal is manifest from the closely similar sequence of changes during their development; from the almost equal rapidity in which they appear and disappear, and from the fact that in this case a common cause induces both to appear. As in the wheal, there is at first a blushing of the area, followed by rapid swelling, which quickly spreads the while it grows paler and becomes eventually surrounded by a slightly-reddened zone of skin. The borders of these hard swellings are not well-defined, and almost evanesce into the adjacent skin, and there are no subjective symptoms accompanying them when matured, not even one of tension.

The case appears to me to be a hybrid of three conditions: (1) Common acute urticaria, (2) urticaria gigans, and (3) acute circumscribed cutaneous œdema. The patient has felt slight, obscure, and wandering muscular discomfort at times, which may be attributed to chronic rheumatism, though she has never had acute rheumatism, nor is there any parental history of the disease. She is somewhat of the "rheumatic constitution." It is difficult to say anything definite upon the results of different treatments, as the duration of the condition, in spite of drugs, would appear in this case to bear a direct relation to the magnitude of the exciting cause; that is to say, it is the severity of the chill—a difficult factor to reckon with—which chiefly determines the severity and persistence of the condition, and therefore in different attacks it is impossible to tell what their duration would be apart from the treatment employed.

#### IODINE IN FALSE CROUP.

In an article read before a Louisiana medical society, January 5, 1892, Dr. Watkins (*New Orleans Med. and Surg. Jour.*, February, 1892), said:

The agent which should relieve the paroxysm should also be one which should

radically cure the disease. Such an agent, I believe, we will find in the compound tincture of iodine.

The agent was brought to mind in this way. Time and time again had I heard patrons of the Homœopathic practice, in the course of ordinary conversation, say: "I was waked last night by one of the children having croup; got up, and gave two or three doses of *Spongia*, and the child was relieved." So often did I hear such statements, that conviction came, in spite of opposition, that *spongia* must of a necessity be an agent in the treatment of croup more valuable than any of which I had a knowledge. This being the case, the sooner I added it, or its more scientific equal, to my materia medica, the better for my patients. *Spongia* is made by taking an ordinary sponge, cutting it into small pieces, and roasting it to a rich brown, as we roast coffees. A certain amount of this is mixed with a proportionate amount of alcohol, and when filtered, the *spongia* is completed. Knowing that the essential ingredient of the sponge was iodine, and *spongia* only a very mild tincture, with probably other impurities, the conclusion was reached that the compound tincture of iodine would be of equal value as regards efficiency, and at the same time prove more scientifically exact.

Having on hand about this time a little case (a girl of 2½ years, who had been having these attacks of spasmodic croup for eighteen months, and at intervals of three or four weeks, and upon whom I had about exhausted all the measures I could derive from text-books on the subject), it occurred to me to try the iodine; so a small bottle of the compound tincture, it being mixable with water, was secured, and her next paroxysm rather impatiently waited for. It arrived at 1 o'clock A. M., and the remedy was commenced, giving one-fifth drop dose in water every fifteen minutes. In an hour almost all evidences of the trouble had disappeared, and the same dose was directed to be given at two-hour intervals. When morning came there was not an evidence of croup—in all her other paroxysms some evidences had remained for forty-eight or more hours.

The same dose of the medicine was continued at four-hour intervals, through the day only, for four days. There was not a sign of an attack for thirteen months. When another paroxysm put in an appearance, it was treated in the same way, and eighteen months have since gone by and still no croup.

This treatment has since that time been tried and verified in various instances.

#### VOMITING IN PREGNANCY.

The *Deutsche Medicinische Wochenschrift* recommends the following treatment of vomiting during pregnancy:

℞.—Beechwood creosote . . . . .	m x.
Acetic acid dilute. . . . .	m xx.
Sulphate morphia . . . . .	gr. i.
Distilled water . . . . .	℥ i.

A small teaspoonful every hour until four doses have been taken, then lengthen the interval between doses.

#### MALIGNANT SYPHILIS.

In the *Johns Hopkins Hospital Bulletin*, Jan. and Feb., 1892, Dr. Morison reports as follows: The next case I have to show you is one of malignant syphilis, and I bring it before you because such cases are now fortunately rare. With our present methods of treatment, syphilis is most generally a disease which we can keep well in hand without letting it get away with us, but there are, now and then, cases which seem to defy any treatment, and such is the one before you. Two years ago he had an ordinary chancre of the penis, followed by a roseola in due time. He came to us with a universal tubercular syphilitic (rupia) of the

most aggravated kind, extending from and over his head to his feet. There was hardly a clear spot upon his body.

Every kind of known treatment, external and internal, has been tried, including the subcutaneous injection of formamide of mercury, and they all seemed to be of no avail. At last the ulcerations became so extensive and offensive his whole body had to be dressed with antiseptic and soothing salves and all internal medicine stopped except an ordinary tonic. After nearly six months of this tedious treatment, with an occasional abortive attempt to use either mercury or iodide of potash, or both, he has improved as far as the ulceration of the skin goes, but he has grown worse in other ways. There is a perforation of the roof of the mouth, a partial loss of the septum of the nose, enlargement of both shins, and very painful and well-developed dactylitis. He can sleep very little, even after large doses of morphia, and, although he is at last able to take small doses of the salicylate of mercury, which, by the way, is the best form of mercury I have found, the prognosis is very bad. He may die either from cranial endarteritis or from the syphilitic infiltration of some of the internal organs.

#### THE DETECTION OF TUBERCLE BACILLI IN SPUTUM.

Dahmen (*Münchener med. Wochenschr.*, September 22, 1891), recommends heating for fifteen minutes in a flask placed in a water-bath or steam-bath sputum suspected of containing tubercle bacilli. The albumen is thus coagulated. On cooling, the solid particles and bacteria sink to the bottom of the vessel. The supernatant fluid is decanted and the cheesy sediment is triturated in an agate mortar. From this material, cover-glass preparations are made and stained in the usual way. If the quantity of sputum is inconveniently large, water may be added and sedimentation awaited. It has been found that practically only the sediment contains the bacilli when present. The supernatant fluid may after a brief interval be poured off and the lower layer heated for fifteen minutes in the manner described.—*Med. News.*

### Medical Items.

Lice and other parasites are removed from the hair more quickly by a decoction of quassia, to which a little borax and glycerine have been added, than by almost any other known means.

Great care should be taken in administering tinctures which have stood for a long time in small vials. When the bottles happen to be loosely corked the alcohol readily evaporates, leaving the drug in the form of a concentrated tincture the pharmacopœial dose of which might produce very serious, if not fatal, results.

At a meeting of the Medical Society of the State of New York at Albany, Feb. 5th, a committee was appointed to co-operate in promoting the interests of the Pan-American Medical Congress. The committee consisted of Doctors A. Walter Suiter, A. Vander Veer, James D. Spencer, Seneca D. Powell, W. W. Potter, D. B. St. John Roosa, and John O. Roe.

Dr. Joseph Körösi, of Buda-Pesth, has offered the sum of \$300 as a prize for the best essay on the objects of demography and its progress in the chief countries of Europe and America. The competition remains open until January 1, 1894. The award will be made at the opening meeting of the next International Congress of Hygiene and Demography, at Buda-Pesth, in 1894. The essays may be in either the English, French, German, or Italian languages.

CORRECTION.—The article on stirpiculture, referred to in our editorial column of January 30th, was written by Mrs. Anita Newcomb McGee, of Washington, author of other articles on communistic societies of the United States. It was read before the American Association for the Advancement of Science last summer and was published in the *American Anthropologist*, Washington, D. C., Oct. 1891. It appeared also in the original article columns of the *Herald of Health*.

A bill has been introduced in the Massachusetts House of Representatives, calling for the appointment by the Governor of a commission of five citizens, who shall be known as the Commissioners of Medical Science. It shall be their duty to convene at the call of the Governor, and give hearing to any matter brought before them which has to do with any principle or system of principles looking to the practical advancement of medical science. The Governor and council are authorized by the bill to expend \$5,000 for rewards to further the impetus of genius and research in the development of medical science.

The University of the South, at Sewanee, Tennessee, will open next April its new medical department. It is claimed, the cool mountain weather, already tested by the University for many years, will enable students to study and dissect at times when most of the schools of the country are closed. The faculty consists of several prominent Tennesseans, notably Dr. J. S. Cain, of Nashville, and Dr. J. A. Witherspoon, of Columbia. Dr. H. W. Blanc, formerly of New Orleans, is Professor of Materia Medica, Therapeutics, and Dermatology, and Dean of the faculty. The course is to be three years, and aims at a high standard similar to that of the University of Virginia.

The Health Officer of Chicago states, through the daily press, that an investigation made by him shows that only three deaths out of every fifteen reported at his office as being caused by typhoid fever is correct. This is about the worst reflection on the diagnostic ability of more than two thousand physicians that has ever come under our observation; but it parallels right along with the same official's statement that the lake water at the crib is free from contamination, as shown by chemical analyses made from time to time in his office. Evidently the Illinois State Board of Health are quite skeptical in their belief of these official utterances, as indicated by their appointment of Dr. John H. Rauch as Sanitary Expert and Councillor, with directions to at once examine and report upon the unsanitary conditions which are so productive of sickness, and the high rate of mortality from enteric disease in Chicago.—*Ex.*

An Army Medical Board will be in session in New York City, N. Y., during April, 1892, for examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before April 1, 1892, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidate must be between 21 and 28 years of age, and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the Board. Further information regarding the examinations may be obtained by addressing C. Sutherland, M. D., Surgeon General U. S. Army, Washington, D. C.



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## CONTENTS

### ORIGINAL ARTICLES.

Three Cases of Hæmatoma of the Vulva Following Labor. By Wm. H. Brooks, M. D., Baltimore. 375

Address before the Washington County Medical Society. By T. W. Simmons, M. D. . . . . 377

### SOCIETY REPORTS.

Medical and Surgical Society of Baltimore. Stated Meeting held Thursday, Dec. 10, 1891. Several Papers Read and Discussed. Stated Meeting held Thursday, Jan. 28, 1892. Officers Elected. . . . . 379

### EDITORIAL.

A Dangerous Tendency in Therapeutics. . . . . 383

The New Law Regulating the Construction of Houses. . . . . 384  
The Prevention of Blindness. . . . . 385

### MEDICAL PROGRESS.

Recent Improvement in Microscope Lenses.—Prolapse of the Rectum.—The "Japanese Hot Box" in Eye Practice.—The Tetanus Bacillus. Shall We Operate on Syphilitics?—The Typhoid Germ.—An Effect of Opium on the Eye.—The Faradic Current in Gynecology.—Intra-Venous Injections of Saline Fluid.—A Case of Glanders.—Ascending Microbic Pyelonephritis.—Shall I Send My Patient Away for His Health? . . . . . 386

MEDICAL ITEMS. . . . . 395

## Original Articles.

### THREE CASES OF HÆMATOMA OF THE VULVA FOLLOWING LABOR.

BY WM. H. BROOKS, M. D., BALTIMORE.

Believing that hæmatoma of the vulva complicating and following labor is of much greater frequency and importance than is generally held by the medical profession, the writer has deemed it not amiss to report briefly three cases that have recently come under his own observation. The first two occurred in his own practice; the third in that of a fellow physician who was kind enough to show him the case.

CASE I.—On the morning of January 16th, 1891, I was hastily summoned by Mr. R., a gentleman living in the West End, to attend his wife. She, a healthy primipara, had on the preceding night been delivered by a midwife of a small male child, after having been in labor some forty-five or forty-six hours. She had had no hæmorrhage or other complication until about five hours after delivery, when she observed the appearance of a small tumor upon the left side of the vulva, accompanied by sharp shooting pains in the back and limbs. This tumor continued to increase in size until it was almost as large as the child's head.

The patient finding after repeated efforts that she was unable to pass her water, became greatly alarmed, was told by the midwife that she was "ruptured," and was, when I first saw her, generally demoralized.

Upon examination, I found a hard, tense tumor, dark and shiny in appearance,

involving the whole labium majus on the left side and extending back to the perineum and along the left vaginal wall. In general appearance and shape it much resembled a plethoric Bologna sausage.

The bladder was also enormously distended and occasioned the patient great pain. Failing in my efforts to introduce the catheter, and as the tumor did not appear to be increasing in size, hot fomentations were ordered to be applied to the region of the bladder until spasm of the urethra should be relieved. The applications proved very grateful to the patient and were at her urgent request continued during that day.

On the second day the size and appearance of the tumor were unchanged and the temperature of the patient about normal. She had passed a bad night and seemed much exhausted. On the third day the temperature was still normal and her condition good. During the following night she experienced a slight chill, followed by a rapid rise of temperature. The next morning (4th day) the temperature registered 102° F. The tumor appeared intensely dark, almost black. Quinine was ordered in small doses frequently repeated. The temperature continued to rise, however, and on the fifth day after delivery registered from 103° to 103½° F. The patient complained of great restlessness and sleeplessness. As there were unmistakable evidences of septic infection, it was determined to open the tumor, which was accordingly done by a free incision, extending nearly the whole length of the tumor. A half-pint of blood-clots streaked with pus was removed. The cavity extended along the left vaginal wall, and was about four inches in depth. The cavity was thoroughly irrigated with a bichloride solution and packed with iodoform gauze. A carbolic solution was substituted for the mercury and continued until the tenth day. There was no return of the fever, the patient passed through a rapid convalescence, and on the eighteenth day no evidence of the wound, save a small cicatrice, was visible.

CASE II.—Mrs. E., aged 24 years, married three years, and a primipara. When first seen by me she was in the second stage of labor, but seemed to be making little progress. During a pain, and while bearing down, she felt "something give away," and almost immediately after, a small, elastic tumor made its appearance on the right labium. This slowly increased in size, but did not materially affect the delivery of the child, which was accomplished some hours later. Almost immediately after, and before the expulsion of the placenta, there was fresh extravasation and the tumor increased rapidly in size. The blood dissected the fascia until the whole labium was converted into a hard, compact tumor, oblong in shape and dark in appearance.

The after-birth was removed, and the vagina packed with ice, which had the desired effect of checking the hæmorrhage and limiting further growth of the tumor.

This patient had no appreciable rise of temperature, but as the hæmatoma showed symptoms of spontaneous rupture, it was on the sixth day freely incised, and a cupful of dark, fetid blood, semi-clotted, was removed. The cavity was washed out with a carbolic solution, as in the preceding case, and continued until the tenth day. The case was not seen afterwards, but the writer has since learned that the result was entirely satisfactory.

CASE III.—The patient in this case was a young mulatto girl about 18 years, and also a primipara. She had a normal labor and was delivered of a medium sized female child. Some fifteen hours after the completion of labor a small hæmatoma developed upon the right labium, preceded and accompanied by lancinating pains in the lumbar region, and extending down the limbs. Cold ap-

plications were made, with the effect of stopping hæmorrhage and diminishing the size of the tumor. This tumor was comparatively small, not larger than an almond. No rise of temperature followed, and there were no indications of fever; the tumor was not incised, but left alone to be absorbed. It gradually diminished in size and ultimately disappeared.

1111 Madison Avenue.

## ADDRESS BEFORE THE WASHINGTON COUNTY MEDICAL SOCIETY.†

BY T. W. SIMMONS, M. D.

Gentlemen :—The precedent having been established by our former President for the retiring chairman to deliver an address before our Society, this duty has fallen to me as Acting Vice-President through the year past, on account of the prolonged illness and death of our lamented President.

With this meeting ends the second year of the reorganization of the Washington County Medical Society. The need of this organization in our midst has long been felt. Yet it was feared that any attempt to establish it would receive the approbation and support of but few of our medical gentlemen. A new spirit, however, was imbued by the State Medical Society, which convened in our city, November, 1889, and to-day our worthy secretary reads from the role of membership the names, with but few exceptions, of all the regular physicians of our county and city. This is surely a most unexpected and gratifying showing. Besides, their uniform attendance, manifesting increasing interest, has led to the belief that it has become a permanent organization, one in which it is to be hoped the regular medical representatives of our cherished city and county can assemble together in fellowship, with the highest object in view of our professional advancement. So far, the discussions upon all subjects brought before this body have been well sustained, and in not a few instances strongly conclusive. During debate there has been a pleasing absence of self-intrusion, assumed importance, or unparliamentary doings; indeed, I must say the most commendable deportment towards the chair, and towards each other, has characterized all your deliberations. The character of the papers read before the meetings have mainly proven to be interesting and instructive, and in some instances would have been creditable to medical societies of greater pretensions; but here I would suggest that in the future fewer papers be read than have been at some of the meetings, and in their stead topics be assigned by the president for discussion in case the time of the meetings is not otherwise employed; while one or two papers are admissible, too much time is taken up by the reading of four or five at any one meeting; besides, papers, as a rule, are too much without practical importance, and partake more of literary productions. What members desire and need is a practical exchange of views and experience upon important subjects.

The principal business before the meeting at the afternoon session will be the consideration of a suitable law to regulate the practice of medicine in our State. Nothing would, I am sure, be so acceptable, both to our State medical profession and the people of the State, as a wise and effectual law to this end. It is a subject surrounded to-day, as it has been for many years, by difficulties. A failure to secure a law to protect the people of our State from quackery has been the order of each succeeding legislature for many years, and may so continue for many more to come. The reasons for this failure are several; they are due to a want of appreciation on the part of the people and their representatives as to the

†Delivered before the Medical Society of Washington County, Md., Nov. 11th, 1891.

importance of having such a law, while on the part of the profession it seems to be due to a want of unity as to the kind of law required. I hope that the fact will be accepted by you that any law looking to the suppression of medical imposters is better than none, and that it is not so much what we may consider the best law as it is what law can be obtained.

There are three forms or plans that have been suggested: One by which the fitness of the candidate to practice medicine is solely determined by his college diploma, which is to be passed upon by State supervisors, requiring that the person holding such diploma shall be the identical one named therein, and that it has been issued by a regularly chartered medical school, whether it be from an Eclectic, Homœopathic or regular school of medicine. To all such certificates shall be granted, giving the right of practice within the State. Secondly, the power to be vested in a State board of examiners, to be appointed by the State, who are to examine all candidates without regard to college diploma as to their medical qualifications, and to all such as pass a satisfactory examination, issue a license to practice within the State. Thirdly, a congress, to be composed of chosen representatives of the States, to have full power to determine upon all questions of examination, registration and qualification of medical applicants. Each of these plans may possess advantages to some extent, but, as I before said, it is not so much what we know to be the best plan, but it is what form of law will the legislative body grant and the Governor approve. If a form of law is presented that will strongly defend the people against incompetent medical practitioners, and at the same time maintain the honor, dignity and welfare of the medical profession, as it should do, then will we hear the cry of class legislation raised against it. Indeed, I feel sometimes tempted to say, if the people will persist in having quackery and incompetent medical doctors, why should the regular physicians bother? The people are the absolutely injured ones, and not the medical profession—but yet, when we reflect with patience, and in a spirit of justice, we are bound to admit that the only tribunal competent to handle the subject is the regular medical profession.

It is to be regretted, perhaps, that the medical law of 1888 proved to be deficient after its passage, in a way to render it inoperative. If we could have made our first stand upon this law we could by this time have been free to ask for amendments as might have been required, until, by degrees, a more approved plan would be reached. A similar law to this was granted the State of Illinois, by which it is said over 2,000 medical pretenders were driven out of that State. Would it not be wise to ask the coming legislature for a re-enactment of this law, rather than risk the uncertainty of getting a better one all at once? The law of 1888 is a good one and possesses some advantages which do not belong to the one asked for subsequently. One of the objections urged against it was that it is entrusted to the State board of health, which was ridiculed as a political body. The same might be said against a State board of medical examiners, as it would emanate from the State electorate. To protect the health and lives of the people of our State from quackery and medical imposters would surely be a sanitary act which can most justly come under the jurisdiction of the State board of health—at the same time there would be no enforced association of the two schools as in a State board of examiners, where regular medical gentlemen will be compelled to occupy the same plane of official recognition and importance, side by side with homœopathy—the law may associate them together, but cannot destroy that unity that will ever live in the hearts of a noble profession.

Again, since the standard of medical schools is being raised, the value belong-

ing to the college diploma is becoming more and more important as evidence of the true physician. The action of some of the State board of medical examiners has not proven to be without objections either. They seem to possess great power in the premises and have been criticized as arbitrary, pedantic, etc.

Professor Wood, of the University of Pennsylvania, in reflecting upon the State board of medical examiners of New Jersey, on account of the absurd question propounded to candidates, (such as, give the specific gravity of chloroform; what is dialysed iron, etc?) said that there is not to be found a physician of sufficient repute in Philadelphia to give him a practice of \$3,000 per year that can answer them, and further asserts that he could not answer such impractical questions himself. Some of the questions propounded by the Virginia State board of examiners seem to be similarly absurd, for example: Give the composition of woody fibre; explain the process of explosion; the cause of light in combustion; describe the Island of Reil; give its function and name the important centres in and immediately adjoining. Are such questions practical? If a State board of examiners is to be the plan adopted, then there should be a minimum standard of examination fixed upon whereby the deserving young candidate after years of hard study and much expense may not be annihilated from the profession of his choice because he cannot answer such extreme questions.

It will be impossible by any plan of legislation to make all physicians equally competent, and it must be admitted that those who have had the advantage of high education, and have graduated from high classes, are not always the ones to be found at the head of the profession. I do not wish to be understood as advocating a poor medical education, but to ask that the lines be not too sharply drawn, and thereby exclude from the domain many a promising, deserving young candidate, whose energy, force and aptitude are more than the fashionable, over-acquired education from high places which riches alone can purchase.

The eminent Lawson Tait but recently said: "The young medical tyros of the present day will surely throw over-board two-thirds of their university learning, when they get to that second pupilage which lies in the rough school of experience."

In conclusion, I must express the hope that some form of law may be secured from the next legislature to regulate the practice of medicine in our State; and as so many States in the Union now have medical laws to protect them from medical imposters, it is very important that the doors of this State do not stand wide open to receive them.

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### Society Reports.

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#### MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, DECEMBER 10, 1891.

The 732nd meeting of the Society was called to order by the President, Dr. David Streett.

Minutes of previous meeting read and approved. Dr. Melvin Rosenthal was elected to membership.

Dr. F. C. Bressler read a paper entitled REPORT OF A CASE OF CYSTIC DEGENERATION OF THE CHORION, (Hydatiform Mole). [See page 206.] DISCUSSION.

Dr. J. W. Williams: I congratulate Dr. Bressler on possessing so perfect and beautiful a specimen of this interesting condition. We do not see so many cases

now as the older practitioners did. I gather this from my reading, in which I find so much was said and discussed as to this condition and so many cases were reported, that I am inclined to think that they are rarer now than they used to be.

Virchow, to whom we owe so much in pathology, tells us that they are not cystic, but are a myxomatous degeneration of the chorion, and that they have a mucous tissue within.

*Dr. Bressler:* I think it is Playfair who says that echinococci have escaped from the liver and have set up this hydatiform condition in the uterus: these are always fatal. This kind, if promptly treated, are not fatal. In this the cysts are distinct, whereas in the echinococci form there is one cyst; this is a diagnostic point.

*Dr. Hiram Woods* read a paper entitled OCCASIONAL "HARDNESS OF HEARING" SOMETIMES THE ONLY SYMPTOM OF ADENOIDS OF THE NASO-PHARYNX. (See page 177.) DISCUSSION.

*Dr. Harlan:* It is curious that in these cases of adenoids in children some of them should escape loss of hearing, but some of them *do* escape. Whenever I have seen any symptoms of these adenoids in children under six years of age, they were always to be found. The most notable symptom is mouth-breathing; other symptoms are chronic pharyngitis, "hardness of hearing," etc., and where these symptoms are present they should be treated. Of course where they give no symptoms they require no treatment, as in these cases they shrink up and atrophy at 12 to 15 years of age.

*Dr. Woods:* I make it a point to examine every patient where there are any symptoms of adenoids and in young children, especially if they complain of deafness, I usually find them, and in those cases of deafness where I do not find them they are adults. The particular point I wish to make is that where these adenoids are on the posterior wall of the pharynx, they are dangerous to hearing. When mothers complain that their children "do not hear very well" they should be treated then, and if properly treated they will probably be saved from deafness in after-life.

*Dr. Wm. T. Howard, Jr.,* read a paper entitled THE PART PLAYED BY LEUCOCYTES IN INFLAMMATION, IN THE LIGHT OF RECENT BACTERIOLOGICAL INVESTIGATIONS. (See page 199.) DISCUSSION.

*Dr. R. D. Mansfield:* We are indebted to Dr. Howard for his valuable paper, especially for his suggestion as to the application of warmth, in the shape of hot poultices, to inflamed parts, to assist the leucocytes which are the natural enemies of disease.

*Dr. Hiram Woods:* While the deductions drawn by Dr. Howard are generally correct, we cannot be too rigid in their application. The application of heat in furuncles of the ear will allay the pain, but it is promptly followed by a number of furuncles. This is explained by Lowenberg in his theory that the warmth softens the tissues and allows the organisms of the furuncles to migrate. Incision of the part and the free flowing of blood will cause an abatement of the trouble. In gonorrhœal ophthalmia, cold lessens the congestion and relieves the pain, thus obviating the danger of suppuration of the cornea. Cold applications to such an eye and the instillation of a few drops of a solution of nitrate of silver cause a serous discharge, which allays the congestion. These are clinical facts and we should not lose sight of them.

*Dr. J. W. Chambers:* I think Dr. Howard's paper is confirmatory of clinical facts. There is more than one factor in any infection; every individual possesses

a resistance to certain infections; for instance, the frog resists the action of anthrax, the most virulent infection. So with man: some of us have a greater power of resistance than others. One man will have pneumonia and recover, another man of the same physique will rapidly succumb. In inflammation, the tissues have all they can do to continue the vitality of the part inflamed, and we all know that cold lessens the vitality of tissues. Billoth took the ground, some years ago, that abscesses should not be opened too early; he says that early opening exposes the healthy tissues to the action of the infection. So with bold, deep incisions, they may add to the patient's comfort, but may increase his chances of infection.

*Dr. J. W. Williams:* I endorse Dr. Howard's paper fully, especially that part relating to the blood-clot. My work on the corpus luteum serves to confirm it. Bumm, in a recent work on Sapræmia, demonstrates in the vast majority of cases not only putrefactive bacteria but also streptococci, thus showing it to be a variety of septicæmia. On<sup>d</sup> section of the uterus, he found a superficial area of necrotic tissue containing the organisms, under which was a wall of leucocytes, their object, apparently, being to prevent the organism from further entering the tissues. In virulent cases the wall of leucocytes was not found, showing that they were no longer able to control the inroads of the organism.

*Dr. W. T. Howard, Jr.:* The object of my paper was to direct attention to the part played by leucocytes in inflammation, not to the whole field of inflammation. In answer to Dr. Woods, I would ask how could hot poultices produce furuncles unless there had been a previous infection? As to the use of the knife in inflammation, it does good, not in partly formed abscesses; but in cellulitis of the hand, for instance, where there cannot be enough hyperæmia for nature to cope with the inflammation unaided, there the cutting of the hand allows of a free flow of blood and thus facilitates the migration of the leucocytes to the inflamed tissues.

STATED MEETING HELD THURSDAY, JANUARY 28, 1892.

The 735th regular meeting of the Society was called to order by the President, Dr. David Streett.

Minutes of previous meeting read and approved. The report of the corresponding secretary was read and adopted. It showed an increase of 33 members during the year, with a total loss, from all causes, of 7 members, making a net increase of 26 for the year, the membership at present numbering 120.

The report of the treasurer was read, and after being audited and reported favorably upon by the executive committee, it was adopted. It showed the finances of the Society to be in a flourishing condition.

The following gentlemen were elected to membership: Dr. John D. Blake, Dr. E. D. Ellis and Dr. R. C. Rasin.

The following officers were elected to serve for the ensuing year: President, Dr. Frank C. Bressler; 1st Vice-President, Dr. Herbert Harlan; 2nd Vice-President, Dr. Louis F. Ankrim; Corresponding Sec'y and Treas., Dr. W. H. Norris; Rec. and Rep'g Sec'y, Dr. J. Wm. Funck; Executive Committee, Dr. Wilmer Brinton, Dr. David Streett, and Dr. W. S. Gardner. Committee of Honor, Dr. Chas. M. Morfit, Dr. Wm. H. Schwatka, and Dr. Wm. F. Smith. Committee on Lectures and Discussions, Dr. J. Fussell Martenet, Dr. Jno. W. Chambers, and Dr. A. D. Mansfield.

The Society then adjourned to the banquet hall and celebrated its 21st anniversary, in discussing delicacies of the season, toast and song. Dr. Geo. H. Rohé

was toast-master and presided with the grace characteristic of him on such occasions. The toasts and the respondents were as follows.

The Retiring President, Dr. David Streett; the President Elect, Dr. F. C. Bressler; Our Society, Dr. Wm. H. Norris; Our Sister Societies, Dr. Robert W. Johnson; The Hospital, Dr. W. S. Thayer; The General Practitioner, Dr. Geo. W. Preston; The Specialist, Dr. A. D. Mansfield; The House We Live In, (The Patient), Dr. R. G. Davis. Dr. J. Wm. Funck sang several songs, Dr. H. G. Harryman, accompanist, forty-six members and their guests participating.

J. WM. FUNCK, M. D.

1710 W. Fayette St.

#### CHRONIC GASTRITIS.

In chronic gastritis, the result of alcoholic excess, wild yam is very serviceable and may be prescribed thus:

R.—Tinct. belladonnæ,	.	.	.	mxxiv.
Tinct. nucis vomicæ,	.	.	.	ʒj.
Tinct. diascoræ villosæ,	.	.	.	ʒss.
Syr. zingiberis,	.	.	.	ʒijss.

M. Sig., teaspoonful in water, every fourth hour.—*Medical Bulletin.*

#### THE TREATMENT OF TRISMUS NEONATORUM WITH SULPHONAL.

The *Journal de médecine de Paris* for June 21st refers briefly to a case originally reported by J. Berenyi in the *Therapeutische Monatsheft*. An infant eight days old had suffered from trismus for three days. It had five attacks in five hours. Berenyi prescribed sulphonal by the mouth and by the rectum, in doses of three grains. The attacks diminished in intensity and in frequency immediately after the institution of the treatment. Recovery was complete in six days. During this period the child had taken, in all, a hundred and fifty grains of sulphonal without the occurrence of somnolence or any other unpleasant secondary symptom.—*N. Y. Med. Jour.*

#### TREATMENT OF HYPERIDROSIS.

In the *Revue Général de Cliniqué et de Thérapeutique*, the following prescription for sweating of the hands and feet is given. The application is to be made night and morning. The part is first washed with hot water and immediately afterward the following ointment is applied:

R.—Ichthyol	.	.	.	1 ounce.
Vaselin	.	.	.	1½ ounces.

THE second International Congress of Dermatologists will take place at Vienna from Sept. 5th to the 10th, 1892. Professor Kaposi is president, and Dr. G. Riehl, Bellariastrasse, 12, secretary. The subjects chosen for discussion are: Lymphatic Disease of the Skin from a Pathological and Anatomical Standpoint; the Present Position of Leprosy in Europe; Dermatomyces, and especially with reference to their proportion in France; Late Syphilis; the Anatomy and Development of the Epidermis Pigment; Psorospermiosis; the Principles of the Treatment of Gonorrhœa; Lupus Erythematosus.



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BALTIMORE, FEBRUARY 27, 1892.

Editorial.

## A DANGEROUS TENDENCY IN THERAPEUTICS.

Dr. L. B. Anderson, in a recent contribution to the *Southern Clinic*, sounds a note of warning to young practitioners:

“The impression prevails among a large number of the younger members of our profession that all the light, knowledge and wisdom of the ages are concentrated in this generation, and hence any medical work of the past is esteemed so far behind the times as to be unworthy of notice. Compare, if you please, the articles on the old standard articles of the materia medica in the most recent works with the articles on the same agents in Eberle’s works, and every unprejudiced mind will accord to the latter more sound sense, authentic information, well attested facts and sound philosophy than can be found in any modern work on the same subjects. Why then discard the old for the new? This thirst for the new in every department of medical science is pushing old and reliable remedies to the rear, or perverting, misrepresenting or ignoring their medicinal properties entirely.”

Although we are not prepared to exclude modern works on therapeutics from our library and go back to Eberle for guidance, yet we would recommend any young practitioner who has come into possession of the standard works on materia medica of the past generation to hold on to them.

The tendency of the day in medical text-books is toward great condensation. The most important facts only are noted, and all but the most prominent drugs are excluded. The old-time books were written in a more deliberate fashion, and afford very pleasant reading to one who desires not only the stern facts of science, but a little bit of botany, etc., thrown in.

Occasionally a young practitioner (or a mature one, for all that) is completely floored by a question from an aged patient or an old nurse in regard to the virtues of some tisane or simple, famous in former days as a therapeutic agent.

His text-book of *materia medica* ignores it wholly. The medical dictionary tells him a few facts concerning it which leave him still in the dark. In desperation he turns to the practical treatise of Waring; to the volumes of Eberle, full of pithy illustrations from bedside experience; or to that rich treasury of botanical and therapeutic facts, the great work of Pareira; and finds in these dust-covered monuments of therapeutic attainment just the information that he desires.

We have long purposed, if the time should come when the drugs in fashion are thoroughly mastered by us, to take a little pleasure trip through these treasure-houses of knowledge long ago sealed up and forgotten, and see if we could not find in them many gems of truth cast aside in the eager rush for something new. But, alas, synthetic chemistry, with its weekly or monthly supply of brand new drugs, leaves us hardly time to learn the name of the latest favorite and panacea. Therapeutic agents rush across our mental sky like meteorites, obscuring in their fierce glow even the old fixed stars of first magnitude like calomel and bark, and by their quick succession wholly diverting our attention from the flickering rays of humbler lights which twinkled in the firmament of our father's practice.

Perchance this present meteoric shower shall some day have passed, and then we shall, mayhap, have also passed away, leaving to investigators yet unborn the rediscovery of the ancient implements of therapy buried ages before in the tombs of forgotten generations.

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#### THE NEW LAW REGULATING THE CONSTRUCTION OF HOUSES.

A prominent builder has handed to us a copy of the new city building law, which contains some provisions which will, if duly enforced, prevent the erection in future of those hot-beds of disease, passing under the name of homes, found in many portions of our city, and so sternly criticised of late in articles published in the *JOURNAL*. We may quote from the closing sections of the law.

*Section 86.* Be it enacted and ordained, that the word cellar in this ordinance shall be taken to mean a ground floor, room or basement in a dwelling house, the floor of which is below the level of the pavement.

*Section 87.* And be it further enacted and ordained, that all cellars shall extend underneath the whole house and shall be ventilated from both ends; and in low, damp or made ground, the bottom of all cellars shall be covered with concrete or asphalt to the depth of at least four inches thick, and where floored there shall be at least six inches of air space underneath the floor.

*Section 88.* And be it further enacted and ordained, that where dwelling houses are built upon low, damp or made ground, the ground space shall be covered with concrete or asphalt four inches thick, and there shall be at least six inches of air space between the surface of the concrete or asphalt and the joists of the floor, and there shall be ventilation at both ends.

*Section 89.* This ordinance shall take effect from the first day of January, 1892."

Is it not within the proper sphere of a physician's duty to call the attention of the Health Board to violations of this law which come under his personal observation? We are informed by one of its members that the Builders' Exchange will gladly interest itself in the enforcement of this law in case the city authorities are negligent.

### THE PREVENTION OF BLINDNESS.

A circular bearing upon this subject has been sent us with a request for our co-operation in advancing its benevolent aims. It is addressed to, and copies have been sent by the Board of Health to, the midwives of Baltimore. It reads as follows:

"The undersigned practising physicians of Baltimore were appointed by the Medical and Chirurgical Faculty of Maryland to take measures tending to diminish the blindness in our city and State. About *one-third of the blind* in our Blind Asylums have lost their sight through a disease which is common among the newly-born. This *fearful disease* which causes so much suffering and unhappiness *can often be prevented by proper care. It can nearly always be cured and sight saved if treatment is begun early and kept up.* The disease shows itself by redness and such swelling of the eyelids that the baby cannot open its eyes; the eyes discharge yellow matter. The disease usually begins during the first few days of life. This disease will often cause incurable blindness in forty-eight hours, unless properly treated.

We ask you to impress upon the mothers you attend the *great danger of delaying treatment.* Do not let them waste valuable time in using breast-milk, chamomile tea, quince water and other home remedies, for *a day lost may rob the infant of its sight.* Insist upon sending the child, as soon as the disease begins, to a physician, or, if the parents are unable to procure one, to a dispensary.

You can do much toward preventing the disease by thoroughly cleansing the child's eyes immediately after it is born. Wash the eyes carefully with fresh, warm water and a piece of perfectly clean soft linen. Do not use water or linen which has been used on other parts of the body, but wash the eyes first of all. You will assist greatly in the important work of diminishing blindness,

- 1, By washing the eyes of the newly-born as described above, in order to prevent the disease from attacking them.
- 2, By instructing the mothers whom you attend concerning the *importance of watching the eyes closely during the first and second week.*
- 3, By calling attention to the *dangers of the disease, and the great urgency of prompt medical treatment.*

Hiram Woods, M. D., Chairman, George H. Rohé, M. D., J. Edwin Michael, M. D., Harry Friedenwald, M. D., Committee."

This is a step in the right direction and does credit to the State Medical Faculty. We hope that the committee will not rest until midwives who do not call in a physician for grave ophthalmia neonatorum shall be *punished by law* for their neglect.

On the other hand, it is to be urged that physicians ought to deal gently with midwives who call them to such eye cases; for the recent records of one of our city lying-in hospitals show that the most scrupulous care will not always prevent destructive ophthalmia, even when mother and babe appear to be in good general health.

### Medical Progress.

#### RECENT IMPROVEMENT IN MICROSCOPE LENSES.

In the *Med. News*, February 20, 1892, an interesting review of this subject is given by Siegfried.

Up to the beginning of the last decade it may be said that the limit of performance has been reached, with the lenses in use, composed of the ordinary crown and flint glasses, taking into account the best individual management and technique—the most important element of success in microscopy. Very extensive investigations have been made in the past ten years (chiefly by Drs. Abbe and Schott, aided by an appropriation of \$15,000 from the Prussian Government) with a view to determining what ingredients added to the glass would best secure high magnifying power and distinctness of the image.

The result already realized from these improvements and inventions is that while microscopically we could distinguish objects in the approximate form of circles or squares of a diameter of  $\frac{1}{100,000}$  of an inch, we now distinguish them if 125,000 to the inch. Yet this may make the difference between tracing definitely some part of the life history of a micro-organism, or failing to trace it. There is still on this side of the ocean a doubt as to the stability and durability of the new glass, and the new "apochromatic" objectives made from it. Some of the first objectives from the workshops of the leading opticians in Germany have been returned for the removal of external surface defects—probably of a hygroscopic character—due in ordinary use to extreme sensitiveness and chemical action from atmospheric exposure. But the later objectives are more stable and are coming into more extended use when it is desired to attain the highest results in biologic study. There is no longer just reason for denying the superior qualities of these new lenses for definition and management of light and color. For the average worker in biology and pathology, the best lenses of superior crown and flint glasses, in skilful combination, by trustworthy makers, are sufficiently satisfactory for all practical purposes, the cost being also not over a third of the newer apochromatic objectives. As time goes on, improved systems and combinations of lenses are constantly being invented, much use being made of the older crowns and flints combined with the new glass in the same system; and, with the increasing technical skill in smelting, and a better appreciation of the physics of optics, for which the Germans must be given the chief credit, the cost will in all probability, in the near future, be placed within the means of all those workers desiring these improved "oculars" and "objectives." The number of the varieties and kinds of glass used for optical purposes is now upward of sixty-six, and additions to the list are frequently reported.

#### PROLAPSE OF THE RECTUM.

In a lecture upon common diseases of the rectum (*Brit. Med. Jour.*, Dec. 19, 1891), Dr. Heath says:

A mother may come to you saying that her child's body comes down—that is

the expression generally used among the poorer classes—and she at once assumes that it is a case of prolapsus. Now, be on your guard about that, because cases of the “body coming down” are not all cases of prolapsus. Of course many are, but you should observe the case for yourself, and take the trouble to put your finger into the bowel. In many cases you will find that there is a little pedunculated growth hanging there, which, when the child strains, comes through the sphincter or presents at the anus, and which is nothing more nor less than a polypus. These small rectal polypi are not uncommon in children, and the remarkable thing about them is that they generally cause some hæmorrhage. Every time the bowel is opened there is some little blood noticed in the stools, and yet if you come to treat them by taking hold of them with your nail and tearing through the pedicle there is no bleeding, and the case gets well directly. If the pedicle is at all thick it is wiser perhaps to put a ligature upon it, but if it is a simple polypus in a child you may, without scruple, tear through the pedicle with your nail and bring the little vascular body away, and no hæmorrhage ensues. So much for polypi, which you occasionally find in young adults, in whom they become more or less indurated, and, though they are not nearly so vascular, they are thought to be piles. The patient says he has piles, and that every time he goes to the closet the pile comes down, but when you see it, it is simply a pedunculated mass, which should be treated by putting a ligature round the pedicle and cutting it off.

True prolapse occurs both in children and adults. In children it occurs most frequently, I believe, as the result of debility and also, no doubt, as the result of the bad habit which is so common, of allowing children to sit and strain their bowels after they have already evacuated, and at last they strain down the mucous membrane. These are really cases of prolapse. There may be a more severe condition which we call procidentia, where the whole bowel comes down. That is more serious, and I will speak of it presently.

Prolapse may be a symptom of other disease. It is not very uncommon in cases of stone in the bladder to find a child straining to make water and bringing down the rectum at the same time. It is therefore well to bear in mind that you may have another disease behind and to inquire whether the child has serious trouble in making water. But ordinary cases of prolapsus are cases simply of debility, the child is of weak habit altogether, and the bowel has got into the way of coming down on very slight occasions. The great thing is to break through the habit, and if you can make the mother take a little trouble you can break through it readily enough. With a circular opening like the anus very little will bring down the mucous membrane through it, but if you can get the mother to hold the child when it is going to have an evacuation and to put the finger down the verge of the anus and draw on one side, and thus convert the circular opening into an elongated slit, then the mucous membrane is considerably puzzled to come down, and practically it does not prolapse. What I always promise mothers is that if for one week they will take the trouble to do this and so prevent the bowel from coming down the case will probably be cured. In addition to that little manoeuvre it is well, of course, to brace up the bowel by throwing in cold water with an enema syringe, both before and after evacuation, and to give the child a tonic, particularly an iron tonic.

If the bowel comes down and is allowed to remain down for some hours, you may find it rather a difficult job to put it back. The shortest way is to give the child chloroform, then to manipulate the bowel and to return it with the piece of lint with which you have manipulated it. If you simply push the prolapse up

and take your fingers away, it comes down directly; but if you take a strip of lint and then squeeze the blood out of the bowel, you can push the lint and bowel back together, and the lint remaining in the lumen of the bowel keeps it in its place. After some hours the lint will come away spontaneously, or with the next evacuation, and then the case is relieved. In order to keep up the bowel in an obstinate case it is not a bad plan to do as Mr. Ionides did in a case that he had here lately, namely, put a strip of plaster across to hold the two buttocks together, so as to prevent the bowel coming down again.

These cases of simple prolapse are readily enough treated, even in the adult; but we occasionally get cases of procidentia, where the whole bowel comes out, and they are exceedingly difficult to cure. It is curious that women who have that kind of a thing sometimes seem to have a morbid liking for it. They do not want to get cured; it is a form of hysteria, no doubt; they like to be made martyrs of—to be kept in bed, to be always suffering, and to have their friends rallying round them, converting their bedroom into a sort of reception room. I shall never forget one case that I was called to see. It was that of a lady, who was a leading light amongst her religious party, and who had been confined to her bed for many months—I fancy for years—by a large prolapse of the bowel. I was asked to examine her, and I could find no reason why the bowel should not be returned. But she did not want it returned, and she resisted every effort that I made; the moment I put it back she strained and drove the bowel down again, so that I had to give it up as a bad job.

Within the last few years I have been very successful in curing some of these cases in the hospital with the actual cautery. If you have a great prolapsed bowel it will never do to cut it off. If you did, you would probably, just as with a prolapsed uterus, cut off a piece of the peritoneum. But when you have a prolapse forming a large sausage-like projection from the rectum, you can apply nitric acid, which some recommend, but which I do not think quite sufficient for the purpose. I prefer to use Paquelin's cautery. The method is to draw a series of vertical lines upon the prolapse, and then, under chloroform, to put the part thoroughly back, and with the cautery to cut two or three deep grooves in the anus itself, because in these cases it is enormously dilated, and, unless you thoroughly contract up the anus, no power will keep the bowel within. Then, of course, you lock up the bowels with opium, and keep the patient carefully in bed. As far as I have seen, we generally get a cure in such cases, although sometimes the cautery must be applied more than once.

#### THE "JAPANESE HOT BOX" IN EYE PRACTICE.

In a recent article (*Annals of Ophthalmology and Otology*, January, 1892), Dr. Chisolm says:

Two years since when visited by a medical friend from Japan my attention was called to a small flat hot box which he told me was in universal use in that country as a pain killer. The box was a little smaller than the hand in length, breadth and thickness. It was slightly curved in shape as is the hand when it begins to close, so that the concavity can apply well to the rotund parts of the body. The box was made of very thin sheet copper or tin, perforated with a few small holes to allow of the admission of air. Over the top was a sliding lid fitting accurately into the groove. The metal box was covered with colored muslin. The heating power was a cartridge, resembling a large Chinese shooting cracker. It was made of powdered charcoal firing wrapped in paper. It was about 4 inches long, as large in circumference as the index finger, and would burn under slow

combustion for nearly three hours. One of these charcoal packages when lighted and closed up in the box would burn slowly owing to the small amount of air admitted through the perforations in the metal and would keep up a temperature about 120° Fahrenheit. The metal was so thin that the box had but little weight. These pain relieving boxes are to be found in every home in Japan and are in universal use for the relief of pain wherever located.

Hot cloths are so soothing in the relief of eye pains that I determined to experiment with this hot box from Japan. Its size made it a little awkward for eye work, but I found it nevertheless very efficient. It is now one of my most trusted agents for the relief of pain in many eye diseases, such as iritis, scleritides, corneal ulcers and glaucoma. My method of application is as follows: After inserting the lighted fuse and the box has become warm I envelop the box in the folds of a handkerchief and by the ends of the handkerchief secure it to the head. A little loose cotton applied over the closed eye fills up the socket and allows the heat to be transmitted directly to the painful organ. The handkerchief protects the face from the edges of the hot box. Once applied it needs no renewal for two or three hours.

In many cases the relief of pain is magical. In old persons I have avoided the necessity of removing painful eyes lost by glaucoma by the use of this hot box. Previous to its application the disease had resisted both iridectomy and medication, local and general.

The Japanese hot boxes and cartridges can be found at all Japanese stores and are also kept by many druggists. They commend themselves for their convenience, simplicity, economy, cleanliness and efficiency as an application for the relief of pain. I find in them the most valuable method of applying dry heat as a remedial agent.

#### THE TETANUS BACILLUS.

Speaking of the present status of medical bacteriology, Dr. Sanderson (*Brit. Med. Jour.*, Nov. 28, 1891) says: A dozen years ago traumatic tetanus was not regarded as an infective disease. Dr. Heiberg, of Christiania, had given good pathological grounds for thinking that it was so, and several leading surgeons, particularly Sir Spencer Wells, had declared it to be so on clinical grounds. It was not until 1884 that Carle and Rattone found that by the inoculation of pus from a wound which had given rise to tetanus they could induce a similar disease in rabbits. A little later Nicolaier made the remarkable discovery that pure culture of certain bacilli contained in garden soil produced tetanus when injected subcutaneously in animals. Next year Rosenbach produced tetanus in a number of animals by inoculating material from the seat of infection in a case of traumatic tetanus under his care, and found Nicolaier's garden bacillus, both in the original material and in the infected animals.

The effect of the publication of Rosenbach's communication was immediate. On April 18th, 1886, the tetanus bacillus was demonstrated in Dr. Koch's laboratory. Then followed a series of clinical and experimental investigations—in which, as usual, every country excepting England took part—the result of which was that in a very short time the claim of the tetanus bacillus to be regarded as the determining cause of the disease was established on the testimony of a sufficient number of competent witnesses.

Biologically the tetanus bacillus has two interesting peculiarities. Its characteristic form, that of a drumstick, is connected with the fact that each rod is capable of producing a spore at its end, the width of which when mature exceeds considerably that of the rod itself. The obvious presence of spores distinguishes

it from other pathogenic microphytes, excepting, of course, the bacillus anthracis, but the tetanus bacillus is still more remarkable as regards its relation to oxygen. So far, we have found our morbid microbes to be, in the language of bacteriology, facultative anaërophytes, that is, capable of thriving either with or without access of air. The bacillus tetanus is unconditionally anaërobiotic. It was its extreme sensitiveness to oxygen that made it in the first instance impossible to cultivate it otherwise than in an atmosphere of hydrogen. Subsequently Dr. Kitasato found that, in common with other anaërophytes, the tetanus bacillus could be cultivated in tubes without exclusion of oxygen provided that a percentage of grape sugar were added to the gelatine. In this way the tetanus bacillus, which was at first a very difficult plant to grow, has become familiar to bacteriological students from the very remarkable characters which it presents in puncture cultures.

What does this remarkable anaërophyte do in the living organism? It might be expected that in an animal killed by it in the characteristic way that I have described, the bacilli would be found everywhere. On the contrary, no lesion whatever is to be found in any organ, and no trace of the microphyte itself excepting in the immediate neighborhood of the focus of infection. It is therefore obvious that the development of tetanus cannot be described as a contest, a struggle for existence, between the microphyte on one side and the organism on the other, for here the tendency to multiplication, which we once considered as an essential in every infective process, is conspicuously absent. The bacilli multiply, but their multiplication is limited to the seat of infection—to the immediate neighborhood of the wound. In the dissemination of the *materies morbi* they take no part. That is due to a poisonous product of their growth, in respect of which the most remarkable fact that we know is that although in a certain sense soluble, it spreads with extreme slowness through the organism.

#### SHALL WE OPERATE ON SYPHILITICS?

From a very interesting article by Dr. Frank Lydston (*Med. News*, Dec., 26, 1891), on the relation of syphilis to the repair of surgical lesions, we clip some important paragraphs:

I am frequently asked whether a proposed surgical operation is safe, in view of the fact that the patient upon whom it is proposed to operate is suffering from more or less recent syphilis. I also find that general practitioners often advise patients that fall under my care against surgical operations, for the sole reason that said patients are affected with constitutional syphilis more or less remote.

I have been quite observant of the phenomena attending the healing of operation-wounds in syphilitic subjects, and have come to the conclusion that, *per se*, syphilis has little or no effect in retarding repair. In many syphilitics I have had operation-wounds heal with exceptional promptness. An excellent illustration of the favorable course of simple incised wound in syphilitic subjects is to be found in the excision of the primary lesion of syphilis. In a large number of cases of excision of hard chancere I have found that primary union was the rule. In mixed sores I have on several occasions seen reinfection and chancroidal ulceration following excision. I will state that these cases of mixed sores were operated upon entirely experimentally, as I do not consider it good practice to deal with such sores in this manner. In some cases—and in a far greater proportion than those that practice excision have acknowledged—induration of the cut edges will occur, but this only happens several days after primary union of the incision has occurred. If the operation be performed some days after the



chancre has ceased to progress, and has become stationary, induration of the cut edges is not likely to occur. In some instances induration of the cicatrix will occur as a consequence of irritation a week or more after the incision is perfectly healed; but these untoward phenomena are not the result of imperfect repair, but are the result of a rapid proliferation of cells determined by irritation of the cicatrix after the process of ordinary tissue-repair is completed. The question of the possible local character of the chancre and reinfection of the cut surface enters into consideration in this connection, but does not concern us here.

In patients with latent secondary syphilis, suppuration, sloughing and ulceration in operation-wounds are frequently attributed to the constitutional taint when the fault lies in the technique of the operation. Notwithstanding the fact that this explanation is very consoling to the surgeon, it is my opinion that a clean, aseptic operation in patients that are syphilitic, but in whom the syphilis is not in active efflorescence, will heal quite as promptly and perfectly as in entirely healthy individuals. This is not true, however, of suppurating and infected wounds; such lesions heal very slowly or not at all, until thorough and vigorous treatment of the constitutional malady is instituted.

When secondary syphilis is active and severe syphilides are present, any surgical lesion may determine a deposit of syphilized material at the particular point involved. This material may break down and ulceration of tissue result. So far as my observations go, it would, however, seem that this tendency is modified chiefly by the primary resistance of the patient, rather than by the severity of the syphilis, and I think it will be found that when once patients with active syphilis do badly, more reliance is to be placed upon tonics than upon vigorous anti-syphilitic measures. Virulent surgical processes, such as erysipelas, vaccinia, and chancre, occurring in broken-down patients with constitutional syphilis, whether latent or active, are especially liable to determine a deposit of syphilitic neoplasm in the affected tissues.

Bruising of the periosteum and bone is likely to be the determining factor in the production of a node. Ulceration and caries or necrosis are, of course, thus more likely to result than in syphilitic nodes and osseous inflammations occurring independently of traumatism.

In broken-down syphilitic cases suffering from operation-wounds and injuries, my experience has led me to exercise great caution in the exhibition of anti-syphilitic remedies, and I have come to regard the general condition of the patient, independently of his syphilis, as of much more importance than the old constitutional infection; in other words, I find much better results from treating the patient than from treating his syphilis.

The question of the influence of the syphilitic dyscrasia upon the repair of operation-wounds was brought to my mind not long ago by the protest of a physician against my operating upon a case of syphilitic necrosis of the tibia. The physician thought that an operation was unwarrantable, and that repair of the bone and of the operation-wound would not be likely to occur until the patient had had a thorough course of mercury and iodide of potash. The patient has not yet made up his mind upon the question of operation, but most practical surgeons will bear me out in the assertion that an operation will be the surest method of treatment for the patient's general condition.

A case in point is one in which I operated for central syphilitic necrosis of the tibia involving the entire shaft of the bone for about four inches. The question arose in council as to the propriety of operation until after vigorous anti-syphilitic treatment for a few weeks. I advised immediate operation, which was finally

consented to. After removal of the necrotic bone I applied a fenestrated plaster bandage, put the patient upon cod-liver oil, and allowed him to go out on crutches. Repair was quite rapid, and at the end of three months the patient was able to get about without artificial support and had gained about twenty pounds in weight.

#### THE TYPHOID GERM.

In his Croonian Lecture (*Brit. Med. Jour.*, November 28, 1891), Dr. Burdon Sanderson refers thus to the germ of enteric fever:

The discovery of the typhoid fever "germ" was one of the earliest aims of bacteriologists. One after another presented itself, and had to make way for a successor of equal, but no better, pretensions. It was not until 1880 that Koch and Eberth simultaneously fixed upon the micro-organism which has since borne Professor Eberth's name.

In form and even in mode of growth it is scarcely distinguishable from the common saprophyte, which we used to call bacterium termis. It has active movements and locomotive organs in the form of flagelliform processes which are thrown out from either side. These can be much better seen in photographs than by direct observation.

The typhoid bacillus occurs in the affected organs, and more especially in the spleen of patients with great constancy, and can be transferred with such certainty to external media that Dr. Gaikky was successful in 95 per cent. of the cases he examined. It grows luxuriantly in milk, and is one of the few organisms which are capable of vegetating in drinking water. In the organism it of course grows as an anaërophyte, but it is equally or even more adapted to an anaërophytic existence outside. Consequently it must be regarded as much less specific than the bacillus of tubercle, so that on the supposition (the truth of which I do not mean to assert) that both of them were in the distant past derived from harmless ancestors, we should be led to assign a much longer period of modification to the tubercle bacillus than to that of typhoid. Moreover, we cannot, as in the case of tubercle, assert that typhoid is caused by the bacillus, for the experimental proof is wanting. But even without that evidence, and with the knowledge that in all probability typhoid will never be communicated to animals, the constancy of the observed relation between the occurrence and distribution of the bacillus and the existence and development of the disease seems to me (and I believe all pathologists will agree with me) to leave no doubt whatever as to its etiological significance.

#### AN EFFECT OF OPIUM ON THE EYE.

In a recent discussion on opium Dr. Jackson made the following statement: The power of opium to cover up symptoms has been mentioned. This is something more than the power to prevent pain by an action on the peripheral nerves or on the centres themselves. I have seen this illustrated in some cases of insufficiency of the eye muscles. I have one patient with hyperphoria of six centradts, who has suffered much from headache and other effects of eye-strain. If she takes three-fourths of a grain of opium, the hyperphoria entirely disappears. She is not hysterical and is not an opium habituë; she goes many weeks and even months without a single dose. For several hours after taking the opium the conditions of nervous action are so radically changed that the hyperphoria no longer exists, so far as we can in any way discover it. My attention was called to a similar case by my friend, Dr. Charles H. Thomas. In these cases there is certainly some peculiar effect on the co-ordination of nerve impulse so that both the pain and also its cause are for the time removed.

In regard to the lessened importation of opium, it occurred to me that this might be connected with the introduction of hyoscine and some of the coal-tar derivatives, and their wide use by both the profession and laity; also with the attack led by the abdominal surgeons on the use of opium in what was formerly regarded as its peculiar province, the abdominal inflammations.

#### THE FARADIC CURRENT IN GYNÆCOLOGY.

In the *Brit. Med. Jour.*, Nov. 28, 1891, Drs. Aust-Lawrence and Newnham write:

Although relief of pain is very marked by the use of the galvanic negative pole within the uterus, yet the best agent for this purpose is the faradic current. To relieve pain by the faradic current it is necessary to attend to a few brief directions.

In a very large class of cases, all that need be done is to place one electrode over the sacrum and the other in the groin, and apply the secondary faradic current very weak to begin with, and gradually increase its strength as much as the patient can bear. In other cases one electrode may be placed in the vagina, the other in the groin. In another set both poles may be placed in the vagina, using the bipolar vaginal electrode. It is only by testing each case that it is possible to say which mode of administration will give the most relief.

The effects derived from the secondary faradic current in these cases, and used as we have described, are as follows:—

1. A marked diminution in the sensitiveness of the parts in the course of the current, and to which the electrodes have been applied. If it is a case of painful and prolapsed ovary that at the beginning of the sitting cannot be touched without inducing great pain, it can be firmly pressed on at the end of the sitting without causing pain, and this condition will last some hours after the application. To obtain permanent relief, the application must be made night and morning for about ten days, then daily for about twenty more days; at the end of this time, in the majority of cases, the nerves in the painful organs or tissues cease the power of conveying pain, yet the organs or tissues still remain as they were before the electricity was used.

2. We believe the current does assist absorption of effused products, but of this we can not be sure. Our principle object in using this form of electricity is to relieve pain, and in the majority of cases where a woman complains of pelvic pain, one can relieve her to a very great extent, and remove entirely in a large number of cases the pain she complains of.

This electrical treatment is of very great value in a class of cases where any aid is welcome; treatment can be carried out so easily—any nurse can do it, or the patient can do it herself—and the expense is slight, as these batteries can be hired for a few shillings a week.

#### INTRA VENOUS INJECTIONS OF SALINE FLUID.

At a recent session of the Sheffield Medico-Chirurgical Society (*Brit. Med. Jour.*) Mr. R. J. Pye-Smith read notes of a successful case of intravenous injection of saline fluid for hæmorrhage. A man, aged 26, was admitted to the Sheffield Public Hospital on September 25th, having been accidentally shot in the left leg three hours previously. He had large lacerated wounds, with compound fracture of tibia and fibula. He had bled profusely, and when admitted was much collapsed. A pint and a half of  $\frac{3}{4}$  per cent. saline solution was injected into the saphenous vein, with marked improvement, and amputation was performed just below the knee. The circulation then failing again, another pint and a half was injected before he recovered from the ether, and at once his pulse

and color were greatly improved, and in a few hours he completely rallied, and subsequently made a good and rapid recovery.

#### A CASE OF GLANDERS.

Dr. Barker, of St. Louis, reports a case in the *Medical News*:

L. W., colored, eighteen years of age, has been employed removing ashes, slops, etc. He entered the city hospital, November 17th. His mental status was quite low, so that his previous history was scarcely obtainable. There was no evidence of any venereal disease, and he gave no history of injury. He stated that two weeks previously to his admission he first noticed a swelling on his forehead over the frontal sinus; that considerable coryza soon set in; that he picked at the swelling, which increased and soon involved adjacent parts. On his admission, some days later, there were irregular nodules about the central and lower parts of the forehead. These proved to be pockets of pus, the skin being intact over them. There was much œdema about the eyelids, extending to the nose and cheeks. There was a small break in the skin over one of the nodules on the forehead, and, by pressing upon the swollen parts below, pus was forced through this opening above, showing rather extensive purulent infiltration. It seemed that systemic disturbance had not been very great heretofore, but it became so now. The temperature was 101°. Two days after his admission the man complained of pain and of impaired function at the right elbow. On examination a small semi-fluctuating swelling was found on the flexor side of the right elbow. The temperature next day rose to 104°, and his condition steadily became more aggravated. Pus was found in the swelling at the right elbow. Two days later peculiar pustules appeared in various parts of the body, varying in size from that of a pinhead to that of a five cent piece. The numerous lesions were all covered with epidermis and extended quite deeply, containing a milk-like pus. These were incised. The older lesions on the forehead and nose had now assumed a very repugnant character, the tissues all steadily sloughing away in a horrible manner. Latterly delirium was pronounced. The patient died November 28th. On post-mortem examination one lung presented an extensive purulent focus. Dr. Bremer, of St. Louis, made a microscopic study of the contents of the pustules and confirmed the diagnosis of glanders.

#### ASCENDING MICROBIC PYELONEPHRITIS.

In an able and thorough classification of the diseases of the urinary apparatus, Dr. Gouley (*N. Y. Medical Journal*, Dec. 19, 1891), speaks thus of an especially interesting form of kidney disease:

Ascending microbial pyelonephritis is the outcome of neglected urethral or prostatic obstruction, vesical stones, tumors, tuberculosis, entozoa, foreign bodies, or injuries and diseases of the spinal cord leading to paraplegia, causing stagnation and fermentation of urine in bladder, and of the use of unclean surgical instruments, particularly catheters. The phlegmasiac action creeps up the ureters and reaches the renal pelvis and uriniferous tubes, where several species of bacilli and micrococci find abundant sustenance, multiply rapidly, and finally, invading the inter-tubular substance, constitute one of the mechanical factors in the suppuration which generally occurs in both kidneys. The process at first may be very slow, and the struggle between the leucocytes and microbes may last several weeks or months, in rare instances several years, when suddenly, perhaps, on the accession of new colonies of these microbes, it becomes very rapid; and sometimes death is hastened by the supervention of a superacute phlegmasia thus induced or incited by an operation which, under the circumstances, no prudent surgeon would countenance.

*Treatment*—In the management of microbial pyelonephritis it should be remembered that any unrelieved source of urinary obstruction leads to stagnation and fermentation of urine in the bladder causing in time grave alterations of structure in the kidneys, to which palliative measures only are applicable. In the case of urethral stenosis these palliative measures consist in gradual dilatation of the strictured urethra. In the case of prostatic obstruction, they consist of periodical evacuative catheterism. In both cases they consist in counteracting fermentation of urine in the bladder by frequent irrigations with antiseptic fluids.

The quantity of urine passed each day should be constantly kept in view. In case of oliguria or of polyuria, prompt measures should be taken tending to re-establish the normal secretion of the urine. In case of oliguria, which is sometimes the forerunner of anuria, mild diuretics and diaphoretics are indicated. Digitalis infusion and small doses of alkaline diuretics, such as acetate or citrate of potassium, and borage tea, or any other similar beverage, answer the purposes of diuresis and diaphoresis. In case of polyuria, ergot extract in pills may be given in doses of two or three grains, repeated three or four times daily. Gallic acid, in five-grain doses dissolved in glycerin, is also sometimes useful in cases of excessive polyuria. The remainder of the general medication consists in opiates to relieve pain, diluents, occasionally moderate doses of benzoic acid and biborate of sodium, reconstituents, mild stimulants, and a properly regulated diet. Such local and general medication greatly promotes the comfort of patients, and in some instances helps to prolong life.

#### SHALL I SEND MY PATIENT AWAY FOR HIS HEALTH?

My object in writing these few words is simply to call the attention of the profession to what I consider a most important subject. If you have patients who you think will be benefited by a change of climate, be sure first that you are not going to sacrifice advantages you have already for an idea that will not materialize; remember the climate *alone* will be of no value whatever.

Study your case from the standpoint of the individual, as well as his or her disease, and select your place from actual knowledge, either derived from your own personal experience after a thorough investigation, or from that of others who know. When you have decided, write to a prominent physician of the place, give him a history of the case, your diagnosis, the stage of the affection, your patient's temperament, his or her financial condition, and be advised by the doctor as to the probability of success. Let him secure the necessary accommodations, take entire charge of your patient upon his or her arrival; be sure to impress upon the sick one the necessity of following out the instructions of the local doctor, who, from a large experience, is conversant with all the features of the case, and alone competent to bring it to a successful issue. The "home" doctor should surrender his case *in toto* to the one to whom he trusts it, and he should impress his patient with the necessity for the same obedience and implicit confidence that he himself would exact.—Dr. Keating, *Climatologist*.

#### Medical Items.

Professor Rosenthal, by recent calorimetric determinations, came to the positive conclusion that in simple fever there was no increased production of heat, but merely a diminished loss; and that, in fact, for several hours after its inception there was a greatly diminished production, especially during the chill.—*Sanitary Era*.

Professor Holland directs that, in making ferric hydrate, the *antidote for arsenic*, calcined magnesia or aqua ammonia in excess should be added to tincture of chloride of iron, both being well shaken together. In this way, f ̄ij of the tincture of chloride of iron yield enough of the ferric hydrate to be an antidote for ten grains of arsenious acid.

The Forty-third Annual Session of the Medical Association of Georgia will meet in Columbus, Ga., on April 20, 21, 22. The officers are: President, G. W. Mulligan, M. D., of Washington, Ga.; Vice-Presidents, James M. Hull, M. D., of Augusta; Mark H. O'Daniel, M. D., of Macon; Treasurer, E. C. Goodrich, M. D., of Augusta; Secretary, Dan H. Howell, M. D., of Atlanta, Ga.

*Demorest's Monthly* well says that "the less babies are talked to and noticed the first year the better. All success in training them, indeed, depends on this calm letting them alone, leaving the nerves unwrought upon, and allowing the little frame time to become accustomed to the strain upon it of acquaintance with this restless, rioting world of ours." There is also great wisdom in continuing this kind of wholesome neglect through childhood and youth. People are afraid their children will be dull and backward if they are not excited to forwardness. There may be instances of this need, but they are certainly very rare in the present generation.—*Sanitary Era*.

Dr. Charles M. Shields, of Richmond, presented a paper on the treatment of goitre by electrolysis at the last meeting of the Medical Society of Virginia. He applied the electrodes to the surface of the skin—the *labile* method. Four cases of fibrocystic goitre were reported that had resisted the usual treatment. Three had been cured, and the fourth reduced two-thirds. The current from fifteen to thirty Leclanché cells had been used; the sittings had been from twenty to thirty minutes long, and from two to six days apart. Treatment had continued from six weeks to six months. The author did not have confidence in it for fibrous goitre, but considered it the safest and most efficient means at our command for the fibrocystic form.

The *Lancet* draws attention thus to recent exposures of the evils of public hypnotic exhibitions:

At Amiens a confiding person has just been robbed of a considerable sum in bonds and cash by Madame Moret, professing to be an agent of the "Society of Diviners of Paris." Another victim in Belgium fell into a state of catalepsy and unconsciousness, which lasted for three or four days—not, by-the-by, a very unfrequent occurrence. Of the mischief arising from these practices there can be no doubt, while any benefit which may have been derived from them is very slight and problematical. As to the power of divination, or clairvoyance, or telepathy, it is, from beginning to end, a scandalous imposture or a miserable self-deception. Of the number of telepathists and clairvoyants ready to give divinations for cash or for notoriety, not one has ever succeeded in telling the number of a bank-note hidden in a properly secured box. This test has been repeatedly offered and applied, but any attempt to fulfil it has been failures.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.

Any one sending the following numbers of the JOURNAL in good condition will be paid ten cents for same. Vol. XXVI, No. 1, Oct. 31, 1891; Vol. XXV, No. May 9, 1891.

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## CONTENTS

### ORIGINAL ARTICLES.

Influenza ("La Grippe"). By Edward D. Ellis, M. D., Baltimore. . . . . 397

The Treatment of Trachoma (Granular Lids), with Special Reference to the Method of "Expression, and to the Use of Knapp's Roller Forceps. By Hiram Woods, M. D., Baltimore. 402

### SOCIETY REPORTS.

Baltimore Medical Association. Meeting held Feb. 22, 1892. Influenza. Discussion. . . . . 405

### EDITORIAL.

Who Make the Opium Slaves? . . . . . 409

Wanted: A Substitute for Opium in the Pelvic Pains of Women. . . . . 410

### MEDICAL PROGRESS.

Disease of the Ethmoid Bone and Frontal Sinus.—Spotted Fever.—Dress Reform.—Brandy and Influenza.—A Neglected Field of Medicine.—Treatment of Urticaria.—Antipyrin in Diarrhoeas.—For Tapeworm.—For Incontinence of Urine.—Local Anæsthesia.—Pelvic Inflammation in Women.—On the Torsion of Arteries. Actinomycosis Hominis.—Treatment of Liver Abscess by Siphon Drainage.—The Brain in Influenza.—Irritable Bladder. . . . . 411

MEDICAL ITEMS. . . . . 418

## Original Articles.

### INFLUENZA ("LA GRIPPE").\*

BY EDWARD D. ELLIS, M. D.

Mr. President and Gentlemen:—The sketch which I have the honor to read to you this evening was begun during the last days of the "old year," and at a time when no thought was entertained of ever reading it in public.

Having seen a large number of cases of "influenza," in my short professional career, it occurred to me that it would be profitable, as mental discipline, to see how nearly correct I could describe the symptoms of this disease. Consequently, I have written those facts which struck me most forcibly and have omitted to mention many symptoms, which do not stand out so prominently from a general practitioner's point of view. In pursuance of my original idea, and in order that what I thought I had observed should not be hopelessly mingled with the observations of others, no authors on this subject have been consulted, and I alone am responsible for the following:

In this latitude after the hot days and sultry nights of August have passed, and the warm days of September, with their cool nights, linger with us, some relief is experienced from the routine of gastro-intestinal complaints. It is then especially that a particular group of symptoms presents itself, and occupies much of the time of the busy physician. The patient is chilly and has a soreness and stiffness in the small of his back, and in the joints. With a little ma-

\*Read before the Baltimore Medical Association, February 22, 1892.

neuvering, his medical attendant can elicit the important information that he is tired and has not much inclination to perform the duties of the day. Mayhap, as evening approaches, frontal headache commences and is repeated on the following afternoon, preceded by the same malaise, and possibly a slight chill in the morning. Last year the advent of autumn brought with it large numbers of these cases, but as winter approached with cloudy days and cold rains, they began to depart from their usual type and either presented unusual symptoms or some of the more common ones were exaggerated.

And this was especially true as regards those symptoms referable to the respiratory tract. Instead of slight bronchial irritation and moderate dry cough, the expectoration became abundant, and violent and painful efforts were necessary to expel it. Possibly a week had elapsed before the transition was completed and it became evident that malaria was not the sole cause, at least, of the symptoms presented. During the early fall the air was cool and bracing, and sunny days were the rule, but about December 1st damp weather with frequent fogs was almost continuous until December 28th. Those days upon which the greatest number of cases were seen were preceded by damp and foggy weather, while a day or two of bright sunshine appreciably lessened the number of cases and mitigated the severity of the symptoms.

The group of symptoms recognized as malaria did not disappear, but was not met with so frequently as in former years. This new group usually appeared complete in most of its details in all patients, while a few presented symptoms of unusual severity seeming to denote profound toxæmia.

The greater number of cases were preceded for two other days by general malaise, accompanied by constipation. A smaller number began suddenly, attacking the patient while performing his daily work. In these cases a sudden chill of considerable intensity occurs and he is prostrated by great muscular weakness. In the majority of cases a few chilly sensations preceded a pronounced chill or they themselves usher in the attack. The chilly feelings are not limited to the commencement of the attack, but occur several times daily as cold sensations in the back, followed by warm flushes suffusing the patient. In a few cases well marked chills were repeated on the second day of the disease and preceded the diurnal exacerbation of the fever.

Although in some cases the temperature rises rapidly to considerable height, and remains so for three or four days unless the proper treatment be instituted, in most cases the temperature is but slightly elevated and seems to be of a remittent type.

With the initial rise of temperature neuralgic pain and muscular soreness is experienced. The neuralgia is nearly always severe and its usual seat and place of greatest intensity are the supra-orbital and temporal regions, although great pain and tenderness is not infrequently felt along the nerves of the occipital region, associated with painful stiffness of the neck. Intercostal neuralgia also seems to be quite frequent and severe, causing oppressed breathing, sometimes amounting to marked dyspnoea. Again, cardiac neuralgia occurs, the pains running along the left margin of the sternum into the root of the neck and down the left arm.

The pain experienced, however, is not all neuralgic. Indeed, second only to the cephalalgia in severity is intense soreness in the lumbar muscles, which is most marked on flexion of the back. It is not limited to this region and the extremities, as is the rule in malaria, but over the whole body; it is sometimes extreme and the muscles are tender on manipulation. Numbness and tingling in the ex-



tremities occur, associated with hyperæmia of the skin, and may persist for one or two days. Although, as has been stated, the temperature is of a remittent type, these painful and distressing symptoms undergo but slight amelioration when it falls. The retinae are abnormally sensitive to light, and the room was usually found darkened, with the patient's head buried in the bedclothes. As still further evidence of the cerebral congestion, abnormal sensitiveness to sound, injected conjunctivæ and congested face, with tortuous superficial veins, are found filled to engorgement. As a result possibly of the partial stasis in the cranial circulation, vertigo occurs most marked when arising from the recumbent posture. The pulse varies from 90 to 110. One is surprised to find it so slow, for it is the exception for it to be over 100, and frequently where the other symptoms are well developed and one would expect to find it rapid and bounding, it is slow (about 90) and soft. Occasionally dirotism is noticed. Profuse sweats occur irrespective of a chill or fall in temperature. The water stands out in beads over the entire body. It may occur several times during the day, or, as in other cases, is most marked after the disease has subsided and the patient is convalescent.

Beginning on or about the second day with a tickling in the throat, the cough soon becomes frequent and a little thick mucus is brought up. The expectoration rapidly increases in amount, and in a few hours large quantities of it may be expelled after each effort. So much, indeed, is formed that it becomes a source of great danger to elderly patients and those enfeebled by previous ill health. As a result broncho-pneumonia in many respects similar to that due to hypostasis occurs with great readiness. Although the cough usually is easy and the expectoration is readily brought up, occasionally severe paroxysms occur and expectoration is scanty. Not infrequently with each cough, a severe pain, apparently of pleuritic origin, is felt in the side. It usually becomes much less when free expectoration occurs. Respiration is accelerated, especially when large quantities of mucus are in the bronchial tubes. The physical signs are what one would expect. All sizes, and almost, if not quite, all kinds, of moist sounds are heard. Bronchial breathing is also heard from time to time and in different situations. It is heard more frequently in that form of capillary bronchitis than in those uncomplicated by an infectious disease. Associated with these sounds creaking and grating is heard, due probably to previous pleuritic trouble. Again, another condition is noticed, and consists in slight dulness on percussion. Auscultation discovers broncho-vesicular breathing and a few moist rales. This condition, which seems about to develop into pneumonia, rapidly changes as the arterial tension recovers, many moist sounds are heard and the bronchitis is fully developed with profuse expectorations. During the first stage of this condition, the expectoration is scanty, thick, muscular and tenacious, readily adhering to the bottom of the inverted receptacle. Occasionally blood is seen in threads throughout the mass. Not infrequently, and especially in young adults and children, vomiting occurs during the reaction. It sets in after the initial chill, and is most persistent when a thick brown coat on the tongue and constipation with discolored scelerotics indicate hepatic congestion. Although constipation is the rule, loose passages accompanied by tenesmus are occasionally noticed, and they may contain blood. In one patient this condition lasted for two days. Besides the hæmorrhage into the bronchial tubes and intestines, epistaxis also occurs and may recur for several days.

All ages seem to be susceptible to the disease. The oldest patient was a woman 81 years of age, and the youngest who had unmistakable evidence of the disease was only eight months old.

It is remarkable how greatly prostrated are the victims of this disease. After three or four days' illness a patient of vigorous habit is so enfeebled that he can with difficulty maintain an erect posture. The heart muscle is greatly weakened as if but just recovering from the effects of a muscular paralysis; an insufficient quantity of arterial blood is sent to the brain and giddiness and disturbance of vision are the result. Again, as a further consequence of this muscular prostration, a predisposition to respiratory diseases is created and pneumonia and pleurisy occur. At the same time, if the system harbors any constitutional vice it contributes its part in retarding the patient's convalescence. After the disease has passed neuralgias are prone to recur for several days and may be quite severe.

That these cases form a distinct type of disease, I think is certain. The usual violent onset, succeeded by marked muscular soreness and great depression of the vital functions; the almost constant bronchitis; the severe and persistent neuralgia; all, to my mind, set these cases apart and form a distinct group in themselves.

Although the daily papers report greatly increased mortality in our large cities and ascribe it to the influenza, I must confess such has not been my experience. From the cases I have attended, I am compelled to regard it as a disease with a low mortality. Not having kept count of my cases it is difficult to say just how many I have attended during the months of November and December, but I am quite sure I have been able to draw these observations from 300 cases. Of all these patients I have not lost a single case which I could ascribe to influenza. Again, it would seem that those cases, which begin suddenly with great muscular pain, neuralgia, etc., are most amenable to treatment, the average duration being four days. It is different, however, when the disease exists several days before its true character is exhibited, or when treatment is delayed a day or two. Then it pursues its course unchecked and the prolonged action of the *materies morbi* produces a predisposition to relapse and the persistence of obstinate neuralgia. It may be questioned whether those cases in which a relapse occurs are not malarial in origin. Although at first I was inclined to believe they were merely examples of intermittent or remittent fever, yet I found that the relapse usually occurred on about the third day, and in those cases in which proper treatment had not been sufficiently persevered in, about the time the patient would emerge from under the influence of the treatment received; and further, it was noticed that quinine alone will not cure the disease.

This recurrence consists in a reappearance in miniature of the symptoms of the first manifestations of the malady, except that the neuralgias are most marked. I hardly feel justified in labeling influenza the disease I have attempted to describe. As regards some points it does not correspond with the authoritative statements of authors. It is said that influenza is unaffected by climate, seasons of the year, barometric condition or race. But although blacks as well as whites are affected, the foregoing group of symptoms is markedly influenced by the seasons and barometric conditions.

In 1890, 1891, it first showed itself endemically about the first of December, and last year it continued on through to Feb. 1st, and then came a lull until the first two weeks of March, when it became very prevalent again. Since the first of January of this year it has not been met with so frequently as during December. I think this group of symptoms is the manifestation of an infectious disease, because great numbers of persons, separated from each other squares away, are affected in precisely the same manner and at the same time. Again, it bears a marked resemblance to the effects of alkaloidal poisoning in its rapid onset and

the great enfeeblement and the perverted stimulation of the physiological processes; so great indeed is the prostration produced that permanent organic lesions remain and oftentimes greatly compromise the patient's life. Treatment indeed bears out the analogy, for, by sustaining the patient's vitality until the toxic substance is eliminated, life is preserved and serious organic lesion may be prevented. Like some other infectious diseases, it does not render its victims immune; for after a certain time another well-marked attack may be received.

I have never been able to convince myself that the disease is contagious, and yet, when I ask myself the question, I am inclined to answer that it is. Not only once, but many times I have seen first one attacked by the disease when the other members of the family were apparently quite well and during a few days the whole family were attacked one, by one, by the disease.

Although this might seem to suggest that the incubative period is from twenty-four to forty-eight hours, I am quite sure more time is required for the development of the disease. Four days, I think, will about represent this period.

All that has been said, however, has but little practical value except in so much as it may serve as a guide to the proper treatment. It is remarkable how opinions differ as to what constitutes it. One gentleman, who is an authority upon questions of medicine, once expressed the opinion that the solution of the acetate of ammonium and alcoholic stimulation seemed about as effective as anything else. His idea being not to shorten the cause of the disease, but to minister to the patient's mental wants and aid his endurance with alcoholic stimulants. Another, skilled as an operator upon the air passages, recommended the ammoniated tr. guaiac. All are agreed however, that alcoholic stimulants are of great importance during the attack, and aid the repair of the tissues during convalescence.

The plan of treatment which I have adopted and found uniformly successful was suggested by the analogy cases bear to the effects of paludal poison; in other words, to attack the affection as represented by its symptoms.

I am satisfied that quinine exerts a decided influence over the course of the disease; when administered alone, it will not stop the disease in its incipiency, but sustains the patient's strength and prevents profound depression of the circulatory system; as evidenced by the absence of feeble cardiac action and relaxation of the arterial system, favoring the development of bronchitis with superabundant secretion and pneumonia. The dose necessary to accomplish this result is not sufficient to act as an antipyretic, for thirty grains a day of quinine given in divided doses is quite sufficient. Administered in the above manner and dose, it does not materially lessen the fever and has but little if any influence over the duration of the disease, and the muscular pain and neuralgias are but slightly affected by it.

One of the new remedies which may be relied upon to give the patients great comfort is acetanilid. While it does not lessen the danger from pneumonia and cardiac failure it will promptly and completely stop the neuralgia and muscular soreness and appreciably reduce the temperature.

Granting the above to be true, we have in the conjoint administration of these agents in moderate doses a great help, aiding the subject to throw off his antagonist.

The relief experienced is prompt and complete, and if proper care be observed by continuing its administration for three or four days, a cure can almost be promised except in cases complicated by previous organic changes, and the disease be said to have been checked in its very beginning.

THE TREATMENT OF TRACHOMA (GRANULAR LIDS), WITH  
SPECIAL REFERENCE TO THE METHOD OF "EXPRESSION," AND TO THE USE OF KNAPP'S  
ROLLER FORCEPS.\*

BY HIRAM WOODS, M. D., BALTIMORE.

Before entering upon a study of the therapeutics of trachoma, it will be well, I think, to briefly consider its pathological factors. The essential element in the disease is the presence of the trachoma granules, or lymph follicles. Noyes† thus describes them: "They are small, round masses of various sizes, consisting of lymphoid cells and connective tissue cells, surrounded by a fibrous capsule; they are buried in the adenoid tissue of the conjunctiva, and have a yellowish, opalescent or grayish appearance. These granules, when deep-lying, are apt to become indurated and converted into connective tissue fibres, while those nearer the surface are liable to soften, ulcerate, and in this way may entirely disappear.

From this description it can be seen that trachoma, or granular lids, may present a variety of appearances. The conjunctiva—more usually that of the upper lid—may be covered with spawn-like lymph follicles, from which lymph exudes on pressure. This variety has been termed "follicular trachoma." Again, these granules may extend over the fornix upon the ocular membrane, the whole conjunctiva becoming thickened and the cornea vascular. This form is called "diffuse trachoma."

As the case progresses and the lymph follicles are converted into connective tissue, contraction takes place, the conjunctiva atrophies, the tarsal cartilage is often distorted, and we have the so-called "cicatricial trachoma."

The diagnosis of granular conjunctivitis is not justifiable unless the granules are present. Thus, the papillary hypertrophy, so often seen after purulent conjunctivitis, may be associated with trachoma, and conceal the granules, but it does not, as is commonly supposed, constitute granular conjunctivitis. What leads to the *formation* of the granule is a question in ocular pathology which is not satisfactorily settled. Sattler, of Prague, and Michel, of St. Louis, have described a micrococcus, said to be constantly found in the trachoma granule, and capable of producing the disease when inoculated upon the healthy human conjunctiva. Dr. George Lindsay Johnson, of London (*Archives of Ophthalmology*, Vol. XIX, Nos. 2 and 3), says that he "inclines to the belief that the follicles are of the nature of a proliferating lymphoma, due to the irritation of the natural lymphoid tissue, probably by a microbe, and certainly by some prolonged source of irritation." Other observers, again, have cast doubt upon these bacteriological investigations.

The treatment of trachoma has always been a difficult problem. The number of remedies recommended is itself strong testimony of the inefficiency, or rather unreliability, of all of them. The standard remedies have always been blue-stone and nitrate of silver. Some cases slowly get well under these remedies, but the treatment extends over months, and sometimes years. In the meantime, the deformity in the lids usually advances, and more or less corneal opacity develops. Carbolic acid, inoculations with gonorrhœal pus, and infusions of jequirity have been used. Pus inoculations are now discarded, very properly so. Carbolic acid and jequirity still hold their places, and are often effective. The action of the former is slow and painful, while the latter has to be used with ex-

\*Read, with presentation of patients, before the Clinical Society of Maryland, Feb. 19, 1892.

†Diseases of the Eye.

treme care or it can—as I with others have found out by sad experience—do harm.

Destruction of the granules by the electro-cautery, or their removal by excision of the conjunctival fold containing them, have had their defenders. Different surgical procedures, some simple, others complicated, have been suggested, but none have so far come into general use. Based upon the supposed bacterial origin of trachoma, strong solutions of bichloride of mercury (1 to 500, 250, 100), have been advised.

While I was absent from the city last summer, an obstinate case of diffuse trachoma, which had been treated by me for several months with blue-stone with little benefit, was treated with a 1 to 250 solution by Dr. C. W. Hartwig, who attended to my work at the hospital. We kept the treatment up for a month or six weeks before the lids became smooth. Each application seemed painful and was followed by a profuse serous discharge from the conjunctiva.

The method of treatment to which I desire to call especial attention is that known as "expression," squeezing out the contents of the lymph follicles or granules. Six years have passed since Dr. Hotz, of Chicago, gave it to the profession, but it has not yet come into general use, although Dr. Noyes and other leading authors commend it. Dr. Hotz' paper is in the *Archives of Ophthalmology*, of 1886. He used his fingers and thumbs for squeezing the upper, and an old-fashioned untoothed iris forceps on the lower lid. Various instruments have since been devised, the most important of which are the forceps of Dr. Prince, of Springfield, Ill., and Dr. Noyes, of New York. Such instruments have been used more extensively, I think, by specialists in the western than in the eastern States.

What seems to me an improvement on any previous instrument has recently been devised by Dr. H. Knapp, of New York. It is the roller forceps. Dr. Knapp presented it to the American Ophthalmological Society at its meeting in Washington, September, 1891. A brief account of it appeared in the *Medical Record* of October 3, 1891, and a fuller description in this January number of the *Archives of Ophthalmology*. This latter article is based upon a series of 114 successive cases treated from March 21, 1891, to December 16, 1891. It comprised 16 cases of follicular catarrh, of which 15 were cured; 64 of follicular trachoma, of which 54 were known to be cured, 8 not recorded, but doubtless were cured, while 1 required a second squeezing, and the last was treated by another method. Of the remaining 34 cases, 22 were diffuse trachoma, of which 17 were cured, 3 not reported, and 1 had a relapse. Ten were cases of cicatricial trachoma, of which, says Dr. Knapp, "seven were cured as far as these cases can be cured, *i. e.*, with smooth, more or less shrunken conjunctiva, and frequently corneal opacities, but no more irritative symptoms." The other 2 were cases of "horny summer granulations"; one a mild case, was cured; the other, a severe one, was temporarily helped.

"Follicular catarrh" is classified by Noyes and other authors as a variety of trachoma. It presents objectively lymph follicles. "It is," says Dr. Knapp, "like the severer forms of trachoma, infectious." On the other hand, there can be no doubt that it is rarely attended by serious consequences to the cornea, and does not cause the lid deformity seen in other forms of granular ophthalmia.

Mild treatment will usually cure the disease. Leaving out these 16 cases and the two of summer catarrh, there are left 96 cases of trachoma, 10 being already in the cicatricial stage, and 86 undoubtedly belonging to those varieties of the disease which end in scar formation. Of these latter, 71, and probably 79, were

cured by an operation entirely free from danger. Dr. Knapp says that he is "not aware that in the whole series one eye was made worse." He gives the following description of the forceps: "The branches of ordinary, rather strong, forceps divide at their end like a horse-shoe, the free space of which is closed by a creased cylinder which rolls on pivots in sockets."

The accompanying diagram is from an electrotype kindly loaned me by the Messrs. Tiemann, of New York.



The method of using is, for the upper lid—evert the lid and hold the ciliary border with a pair of fixation forceps. Pass one ring of the forceps well back into the retro-tarsal fold, the other coming to the ciliary border of the lid. The forceps are then closed and drawn toward the orbital edge of the cartilage (which has been everted.) The cylinders revolve, one over the retro-tarsal conjunctiva, the other over the tarsal membrane. As the forceps advance, the lymphoid contents of the follicles are pressed out, or the hard old granules are crushed. There is usually some bleeding. The procedure is to be repeated once or twice until the lids look smooth, or the forceps bring nothing away. For the lower lid, the procedure is the same, save that one ring of the forceps is outside the palpebral split on the skin. The after-treatment is practically nothing. I washed the conjunctiva in my cases with a 1-4000 corrosive solution. Dr. Knapp omitted this in most of his, and thinks it unnecessary. He advises anæsthesia. All my cases were operated on under cocaine. Still the suffering is great enough to justify anæsthesia. The sources of benefit are probably (1) removing the mechanical irritant to the cornea; (2) removing, in the destruction of the follicles, the constantly acting cause of the disease—the infectious principle, whatever this is. As regards this latter point, Dr. Knapp doubts if squeezing or any method of disinfection we know will completely remove all the morbid material. He is of the opinion that when a certain amount has been removed, nature can take care of the rest; that it has also been shown that there is little or no danger of reinfection if some of the follicles are left. One of my own cases (II) bears upon this latter point.

I am led to present such a short series of cases as the following without waiting for more clinical experience for several reasons. In Baltimore we see comparatively little of the early stages of trachoma. The majority of cases occur among foreigners, chiefly the German and Polish Jews and Bohemians. Our population among these people is not very great, and I do not care to wait the long time probably necessary to obtain a large number of cases. Another reason is that, as far as I know, treatment of trachoma by expression is not employed at any of our city eye clinics. It has been used at the Presbyterian Hospital—where all my cases were seen—for three or four months only. Prior to its introduction, jequirity was used in selected cases, and blue-stone or carbolic acid in the others. The results of "expression" justify, I think, a report of even these six cases. The forceps were used on two or three other patients, but the results are unknown, so they are omitted.

CASE I.—A German, 26 years of age. Follicular trachoma R. E. Under blue-stone treatment several weeks; no improvement. Cornea slightly pannitic upper fifth; photophobia, lymphoid follicles in abundance in retro-tarsal fold;

few on cartilage. "Squeezed" lid two days in succession under cocaine. Photophobia relieved after first operation. I saw him four days later. Lid was smooth; no photophobia. This occurred the second week in November. Have not seen him since.

CASE II.—Frances S., 9 years old. Diffuse trachoma left eye. Lymphoid follicles in tarsal and retro-tarsal membrane, over fornix, and back part of ocular conjunctiva. Upper fourth of cornea cloudy and vascular. Photophobia so great that the eye was kept closed all the time.

Treatment for several weeks by blue-stone did no visible good. "Operation first week in December, two days in succession. *One operation removed all photophobia and it has not returned.* The second squeezing was done to destroy some follicles well back in the fornix. This was only partially successful, and I have treated them since with nitrate of silver. The child has not had a particle of pain since I first operated. Cornea slowly clearing, retro-tarsal and tarsal conjunctiva free from granules.

CASE III.—Mamie G., age 16. Follicular trachoma of several year's standing; has been treated at various places for a long time. Left eye only affected. A small number of deep-seated hard granulations on cartilage and in retro-tarsal fold. Eye constantly watering. Photophobia, but not so marked as in case II. Upper third of cornea thickly vascular, the rest clear.

Operation done first week in December. Considerable force was necessary to remove the hard granulations, but the lids were left smooth. The photophobia was cured at once. Lids are still smooth (February 19). This case has a sequel which I deeply deplore. I watched carefully the pannus from December 6th to January 4; it did not clear a particle. It seemed to me and to the others who examined the girl's eye, that here was an ideal case for jequirity—a cured trachoma, persistent, dense, pannus. It was accordingly used by the method which has been in vogue at the hospital since 1886; a very little of the fine powder placed upon the conjunctiva. *The typical jequirity inflammation was not unduly severe*, but a spot of infiltration appeared in the clear cornea, and for a time threatened a slough. It has now healed with a clear facet. The pannus has almost entirely disappeared.

CASE IV.—H. F., age 38. Had connective tissue granulations, deeply seated, in tarsal and retro-tarsal conjunctiva. Left eye affected. Light general pannus. Lachrymation, photophobia. Trouble of four years' duration. Has been under treatment at various places before. "Squeezed" on January 30th; considerable force was required. There was some hæmorrhage, and for three or four days the symptoms of irritation were severe. The man is now well, barring the corneal opacities; lids perfectly smooth.

CASES V and VI.—Are now under treatment, and are very similar. They belong to the cicatricial variety of trachoma. Both eyes are affected in each case; cloudy, vascular corneæ, atrophied conjunctiva with thick hypertrophied lids and distorted cartilages. The disease is of 10 years' duration in each case. They are both young German Hebrew women. Case V has left upper entropion. No "cure" is possible for these women, but they illustrated what the forceps can do to relieve the irritative symptoms. I took case V into the hospital February 19th; her photophobia was so great that she could not open her eyes, but was led to the ward. The same day I used the forceps with considerable force; there was an exudation from follicles, or from hypertrophied membrane, in the retro-tarsal fold and a good deal of hæmorrhage. The following day she was able to walk alone into the operating room, the photophobia having almost entirely gone. With the

left eye closed she can stand strong light, and said she had no pain. The remain ing discomfort seems justly due to the entropion.

Case VI came to the hospital for the first time on February 18th. She kept her eyes open only enough to see her way. To-day (February 19th), 24 hours after the use of the forceps, she can keep her eyes open in the strong light of the dispensary without pain. February 23rd, she remains comfortable. A few "wild-hairs" in the upper lid I pulled out yesterday, as they were causing some irritation. The lids are smooth, and she says she is much better.

In conclusion, I desire to say a word about relapses and the use of jequirity. Dr. Hotz (*loc. cit.*) says that if a patient cured by any method of treatment short of destruction of the retro-tarsal fold—a surgical procedure which he considers absolutely wrong—continues to live under the same conditions as those which produced the disease, he can contract it again. Hence a "relapse" is no argument against a remedy which leaves the lids smooth, and removes irritative symptoms. A method which can do this is preferable to one causing such deformity as is caused by excision, even if a certain amount of danger of relapse is left. This seems to me sound reasoning.

When jequirity was in its experimental stage from 1882 to 1885, I made a careful study of its action upon a number of cases. (An account of them was published in this JOURNAL January 24, 1885). I was so unfortunate as to destroy the cornea in one patient in this series—No. 1 of the table then published. The case was one upon which jequirity never should have been used, but this was not known. There was with the granular lids some suppuration, and the cornea was clear. No one would make that mistake now, but I was not the only one who made it during the years 1882-1885; since then, jequirity has had a place among our standard remedies at the hospital. For certainly five years it has been used as recorded in my third case. We have not had a single accident until this one, which fortunately will not be serious. Its use is limited to cases of obstinate pannus—the condition of the cornea rather than of the conjunctiva being the guide. I believe it is easily the best remedy we have for obstinate pannus. There is always the danger, however, of meeting a patient who, like case III, is for some reason or other specially liable to corneal trouble. The difficulty that is sometimes experienced in inducing jequirity ophthalmia led us to abandon the infusion for the powder, and our constant immunity from trouble has caused us to continue in this course. But such experiences one does not want repeated, and, for one, I shall hereafter produce jequirity inflammation, more safely, even if more slowly, by the infusion.

525 N. Howard St.

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### Society Reports.

#### BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD FEB. 22, 1892.

Meeting called to order by Vice-President Dr. S. A. Keene in chair. Reading of minutes of previous meeting, on motion of Dr. Neff, were dispensed with. Committee of Honor reported favorably Drs. Morris Shanks and H. K. Yeakley, who were unanimously elected. Dr. Geer proposed Dr. S. S. Ulrich, Dr. B. P. Muse, Dr. S. T. Earle; the first two were referred to Committee of Honor. Secretary was ordered to notify Dr. Earle that his resignation had never been accepted.



Dr. Friedenwald was granted privilege of following Dr. Ellis in reading his paper.

*Dr. Ellis* read a paper on INFLUENZA. (See page 397.)

Dr. Friedenwald gave statistics showing occurrence of eye and ear trouble in connection with and following la grippe. DISCUSSION.

*Dr. Parker* has had several cases where abscesses had occurred in sub-maxillary glands, and would like to hear from others. Dr. Branham thinks papers just read offered a good many points for discussion, especially as to its being a contagious and infectious disease; he had noticed a good many articles in different journals. In London, a physician had written a paper dealing with the contagion of it, and cited a village in England, where an epidemic was prevented by isolating the case, thus preventing the spread. The point he wanted to make was the occurrence of mastoid diseases. The type was more distinct in his own practice; he had two cases of mastoid trouble accompanied by suppuration of the glands of the neck. Cases were well marked; he opened and drained cavity, and both healed nicely; in one case hearing was restored, another case was a deep abscess, which was entirely healed. He thought the cases were more frequent than Dr. Friedenwald had said.

*Dr. Neff* thought the subject was well discussed at the last meeting, hence there was not much to say. He wanted to speak of rheumatism following la grippe. He had one case he had been treating for la grippe. Went third day and found inflammatory rheumatism. Has had several cases similar, has had none followed by pneumonia, but had several followed by bronchitis, which he thought was harder to cure than pneumonia. He has found bromide ammonia very good treatment combined with chloral; when they failed he resorted to opiates. Has had no abscesses, but had had some ear troubles.

*Dr. Jones* had seen quite a number of cases; had seen abscesses of sub-maxillary glands; one point he wanted to discuss was that he had seen several cases of the septic influence of the disease on the kidneys, causing suppression of urine, high fever, etc.; did not think bromides amounted to much; all have their own opinion as to the disease being contagious or infectious. He thinks it infectious and that there were conditions about the premises which could favor the disease.

*Dr. Parker* thought in the sequence of articular rheumatism the salicylates did great good, but would like to hear from the chair.

*Dr. Waters* thought a very interesting feature of this trouble was the mortality. He had observed treatment in this country far more successful than in Europe. In Paris, antifebrin and quinia had been their stand-by, and the mortality had been great. Our success in Baltimore had been marvellous, for by listening to gentlemen discussing and relating cases of influenza, nobody had died in this city from la grippe.

*Dr. Branham* would like to ask Dr. Jones if those cases of suppression of urine had not followed large doses of antipyretics.

*Dr. Jones:* No; had only given small doses, not very large ones, but had had patients under antipyretic treatment.

*Dr. Branham:* That is what I wanted to bring out.

*Dr. Neff:* Did skin also show evidence of antipyretics?

*Dr. Branham:* Yes; he was pretty sure the suppression was due to large and frequent doses of antipyretics.

*Dr. Parker:* How large doses do you give?

*Dr. Branham:* Not over ten grains; formerly gave larger doses, but since noticing these symptoms rarely ever give over five grains, mixed with bitartrate potash.

*Dr. Chambers* had noticed frequent mental disorders, especially depression, and they don't recover as rapidly as they ought to; in fact, appear much sicker after disease than while they had it, with great inability to do mental work. Also observed in women more or less menstrual disorder. If he was a gynæcologist he would have thought he had ideal cases for removal of ovaries, but he didn't know what to do; did nothing and cases got well; had never had abscesses in his own practice, but had seen cases of Drs. Friedenwald's and Branham's.

*Dr. Keene* thought it seemed strange and hard that the disease had benefited all specialists except the surgeon. He had read many articles and found no two agreed; he thought the doctrine of *Dr. Chamber's* good, because all physicians gave different treatment; he thought question of la grippe was not thoroughly settled; there were more sequelæ this year than ever before and should be more definitely discussed.

In absence of chairman of executive committee, *Dr. Parker* announced a paper for next meeting, "Medical Insurance," by himself. Adjourned.

EDWIN GEER, Rec. Sec'y.

#### ASPIRATION, FROM THE PATIENT'S STANDPOINT.

Shortly after the blizzard of a few years ago I contracted a pleurisy, with effusion from exposure during the storm. The effusion became so large and caused such considerable dyspnœa, dysphagia, and displacement of the heart that it was deemed advisable to aspirate and withdraw some of the fluid. The first needle that was introduced was a small hypodermic-syringe needle, simple for diagnostic purposes. The only thing that I observed at this time was that the pain was much more considerable than I had supposed it would be. Soon afterward another, larger-sized needle was introduced to remove the fluid, and then I noticed that there were two distinct sensations of pain, equal in intensity, but different in character, one as the point of the needle passed through the skin, and the other just before the fluid was reached. The second was precisely the same as the "stitch in the side" felt with a dry pleurisy. A re-accumulation of serum occurring in a few days, a needle was again introduced. Only a small amount of fluid was removed before the lumen became obstructed in some way and the needle was withdrawn and re-introduced in another situation. A few minutes before each of these two aspirations, a four-per-cent., solution of cocaine was injected hypodermically, so that no pain was felt as the needle passed through the skin. The same degree of pain occurred as before, however, when the needle passed through the pleura. These facts would seem to indicate that the pleura possesses nearly, if not quite, as great sensibility as the skin itself.—*Dr. Walter Bensel, N. Y. Medical Journal.*

The following is a favorite prescription of *Dujardin-Beaumetz* for the relief of chronic constipation (*L'Union Médicale*):

Cream of tartar	. . . . .	gr.	xl.
Powdered aniseed			
Powdered fennel-seed	. . . . .	āā	3 j.
Powdered senna-pods			
Washed sulphur	. . . . .	āā	3 ij.
Powdered liquorice-root	. . . . .	5	ijss.
Sugar	. . . . .	3	j.

Mix well. Dose: one desertspoonful in water at bedtime, or whenever most convenient.

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BALTIMORE, MARCH 5, 1892.

**Editorial.****WHO MAKE THE OPIUM SLAVES?**

The excesses committed in the name of gynæcology have often been held up to professional criticism in the medical periodicals. The demoralizing tendency in the case of unmarried women and girls of repeated local applications to the uterus; the rapid oscillation of gynæcological doctrine from cervix-splitting to cervix suturing; the absurd anxiety shown to prop the uterus into an ideal posture; and finally, the iniquity and the cruelty of unnecessary castration, have been made the most of by "conservative family physicians."

Now, gaining courage and self-respect perhaps from the increasing skill and prudence shown in recent gynæcological surgery, the gynæcologist is beginning to hold up to the light some of the errors and crimes of the "conservative physician."

If "gynæcology" makes women sterile, "general practice" makes them opium-eaters. If the gynæcological surgeon's memory is haunted by a stately procession of ghosts which precede him to premature graves, "conservative practitioner's" thoughtful moments ought to be haunted by the mental vision of the array of opium slaves—"his making"—who, from ruined homes and out of the degradation of living perdition, follow with curses the man who taught them the opium habit.

Are such charges ungrounded? Is the general practitioner reasonably careful in the use of opium for women's sufferings?

We had supposed that the recent charges made in this line by members of the Philadelphia County Medical Society were not true of our own community. We regret, however, that we now must admit the guilt of our home profession; for a pamphlet just sent us by Dr. H. P. C. Wilson, one of our oldest and most respected gynæcological surgeons, is very positive on the subject.

Dr. Wilson says, writing in 1890, "nothing in the diseases peculiar to women

has impressed me with deeper horror than the indiscriminate use of opiates for the relief of their sufferings." "Few, if any, come to me with pelvic troubles of years' or months' standing who are not more or less addicted to the habitual use of anodynes." "It is with pain I say that nearly all, if not every one, who has come to me with the opium habit (and they number a thousand or more), *has been led into it by the attending physician.*" "At this writing I have four such cases under my care." "I cannot be too strong in my condemnation of the use of the preparations of opium for the pelvic diseases of women. None are ever benefited by it; all are made worse by it; pain is increased by it, unless the patient is brought to absolute stupefaction; and the recuperative powers of the diseased parts are destroyed by the paralyzing effects of the opiate on the nerves of the parts. It is no use to attempt to cure the physical disease in such a case till we have cured the opium habit, and it is generally more difficult to cure the latter than the former." "I never give a hypodermic for the relief of pain in the diseases of women, and I very rarely give any opiate by the mouth in such cases. Other means may be used to mollify the pains, though not so certainly or promptly; but it is much better to worry with the patient and her friends, than to resort to the prompt and certain hypodermic, which is sure to be demanded again, and is sure to bring reproach and condemnation on the physician who first and secondly gave it. I have never heard more violent condemnations heaped on any physician than on those who first gave the opiate to those who have acquired the opium habit. The patient, the friends, the acquaintances, one and all abuse him for everything that is abominable." "Upon no class of patients do these remedies take so strong a hold as on women, and it is sometimes impossible to cure them of their evil effects. They become opium sots for life, and drag out a miserable existence, a curse to all with whom they are connected." "I did not hesitate to say that there cannot be any diseased condition except advanced (and rapidly fatal) cancer, which justifies the habitual administration of opium for the relief of pain; while there is yet hope of relieving or curing the disease by surgical interference, opium should be studiously withheld, as even with recovery and the acquired opium habit, the last state of that woman would be worse than the first."

These words are not from an inexperienced young enthusiast, but from one who has grown gray in the treatment of the diseases of women. The unusual professional success of Dr. Wilson, as regards quality of practice and pecuniary remuneration, prove that extreme caution in the use of opiates does not blight a young doctor's career.

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#### WANTED: A SUBSTITUTE FOR OPIUM IN THE PELVIC PAINS OF WOMEN.

The evils of opium for such complaints have repeatedly been set forth. Is there any known drug which can take its place? There seems to be no satisfactory substitute, else opium would be very little used. The other anodyne drugs

in common use seem to be too feeble, too uncertain, or too disagreeable to the taste of the patient. Local treatment is not always to be obtained; or, if obtained, may not give relief; or the patient may refuse to submit to it. There is evidently great need of a drug which can be given in a pleasant form—as in tablet or pill, and which can be relied upon in every case to control pain without enslaving or endangering life.

We have thought that aconite might be a substitute for opium in such cases. It is a drug of enormous power, and can with due precaution be safely committed to patients in tablet form (in tincture, it would not be safe to entrust it to careless patients.) It somewhat dulls neuralgic pain, even in certain very severe cases where morphia fails. It has been recommended by some writers in congestive dysmenorrhœa; but perhaps it, or drugs similar to it, might be more extensively applied in other pelvic neuralgias.

We would be very glad to receive communications from readers in regard to its utility in such cases; or to learn of any other drugs which are satisfactory substitutes for opium in those pelvic pains of women which require prompt and certain relief in the rounds of a busy practitioner.

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### Medical Progress.

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#### DISEASE OF THE ETHMOID BONE AND FRONTAL SINUS.

Writing upon tumors of the orbit, Dr. C. S. Bull (*N. Y. Medical Journal*, December 19, 1891); gives the following description of these processes:

A morbid growth confined within the ethmoid cells gives rise either to no symptoms at all or merely to headache. Inflammation of the mucous membrane lining the ethmoid cells may extend from the naso-pharynx, the frontal sinus, the maxillary antrum, or the orbit. The ethmoid cells may be turned into a single large cavity by a collection of mucus or pus within it. So long as a tumor is contained within the limits of the ethmoid cells there are either no subjective symptoms or there are paroxysmal headaches, with a feeling of heat and epistaxis. The orbital symptoms are the same as those of tumor of the orbit. Motility of the eye-ball is limited. The vision may be only slightly affected, or there may be complete blindness. The visual field may not be affected. If the tumor has entered the naso-pharynx, the mouth is more or less open and the speech is nasal. Later there is loss of the sense of smell. If the ethmoid cells are opened into by the growth, there is more or less continuous dropping of cerebro-spinal fluid from the nose, owing to a communication between the upper wall or roof of the ethmoid cells and fissures at the base of the skull. There may also be orbital or palpebral emphysema, and hæmorrhage from the nostril on the same side.

*Mucocele, or abscess of the frontal sinus.*—In chronic inflammatory disease of the frontal sinus there may or may not be supra-orbital pain. If the process is confined to the frontal sinus, there is no other symptom. If, in addition to the pain, there is sensitiveness on pressure over the frontal boss, swelling along the lower surface of the supra-orbital margin and along the inner wall of the orbit, and displacement of the eyeball downward and outward, it is probable that the disease has extended from the frontal sinus to the ethmoid cells. If, in addition to these symptoms, there are coryza, ozœna, and a purulent discharge from the

nostrils, the nasal meatus has become involved and the diagnosis is certain. But, unless all of these symptoms are present, the diagnosis is very difficult and almost impossible. If the first symptom of orbital complication is the appearance of a dense, hard swelling at the upper and inner angle of the orbit, along the superior orbital margin and region of the lacrymal bone, and if the growth is slow and painless, the disease is almost certainly an *osteoma* of the frontal bone, which will eventually involve the orbital plate of the ethmoid, and later the cavity of the skull.

#### SPOTTED FEVER.

This very serious form of cerebro-spinal meningitis has made its appearance near Daingerfield, a small town of about 1200 inhabitants in the northeastern portion of the State. A great number of cases are reported (Feb. 6), and five deaths. The disease seems to be spreading, and much alarm is manifested. So far there has not been a single recovery.

The people in that section should not be satisfied with efforts to cure the disease, but should leave nothing undone to learn the cause. Drinking water out of a well, located in a ravine that drained several premises, produced an epidemic of meningitis in eastern Texas a few years ago. All efforts to stamp out the disease failed, until it dawned upon a neighboring physician to investigate the water supply. As soon as the neighborhood ceased to use water out of this public well, the epidemic gave way, but not until thirteen lives were lost.—(Editor *Texas Sanitarian*.)

#### DRESS REFORM.

In the *Texas Sanitarian*, February, 1892, Dr. Danforth writes:

In every boarding school for girls there should be a female physician to teach them the principles violated in the present mode of dress. Not any especial system of dress reform, but principles involved in the anatomical and physiological construction of the human body. A generation of women so educated would cast aside their present costume as a locust does its outgrown shell. At present, to the masses, any alteration in woman's dress means adopting man's attire. Educated women know better, and that out of the elements of present fashion women of the future will evolve a costume vastly superior to man's in point of beauty and utility. The lesson of fifty years ago is still remembered, and woman's growth in hygienic law is expressed in garments not open to public criticism. The union suit is gaining in favor, as close fitting garments are light and warm, while skirts with tight bands about the waist, which afford a maximum of weight to minimum of warmth, are growing less in number and volume. The corset is being replaced by waists of various kinds, which admit of free motion and do not compress the vitals. Dresses are being made more and more to hang from the shoulders. Realizing the necessity for better dress, the ladies interested in the World's Fair are planning a business suit for officers that will enable them to discharge their duties better than they possibly can in tight waists, long skirts and uncomfortable shoes.

It is idle to talk to women who do not think, and merely accept the world as they find it. The work, like every other reform, must begin in the school-room. A properly educated generation of mothers will never raise their daughters so poorly that their health will break under nature's effort to develop womanhood, and their life string snap under the ordeal of motherhood. Trained nurses will be a potent factor for disseminating principles of hygiene, but intelligent instruction in the school-room will aid both physician and nurse.

## BRANDY AND INFLUENZA.

The announcement that "Lady Brooke's fund for the relief of the distress from influenza" had commenced proceedings by distributing 2,000 bottles of brandy is picturesque, but alarming. It is highly suggestive to the comic cartoonist. If this rate of distribution is to be continued, and to extend throughout the kingdom, the remedy is likely to be worse than the disease. Why these oceans of so-called brandy? Sound cognac is hardly to be had now, even at fancy prices. Will not the encouragement of free drinking and the encouragement of the wretched habit of flying to the bottle as a panacea for ordinary ailments tend to increase precisely that distress which this ill-judged bounty aims at alleviating? If this be Lady Brooke's way of good, it would be just as well that she should not multiply the mischief by holding up her example to the world in communications to the public press.—*Lancet*.

## A NEGLECTED FIELD OF MEDICINE.

In an article upon disease in early infancy, Dr. Ballantyne (*Brit. Med. Jour.*, Feb. 13, 1892,) writes:

It is evident that the difficulties that are met with in the due appreciation of the meaning of symptoms in the disease of infancy are in the main due to a real want of knowledge regarding the laws of infantile physiology. That functional processes in the infant differ in many respects from those in the adult is very evident; and, while in some cases it is known in what way they differ and to what degree, in others this information is not yet forthcoming or not yet certainly agreed upon. The physiology of the circulation and of respiration in infancy has been fairly well ascertained, although even with regard to these processes there are hiatuses in our information; with regard to the digestive functions and those connected with the blood formation, mental and nervous action, and renal secretion, much has still to be learnt. Closely associated with these physiological peculiarities are the better known anatomical differences which distinguish the infant from the youth or man. These, also, have their bearing upon the symptomatology of early life. The great flexibility of the infant's spine, the relatively small development of its lumbar portion, the small amount of grey matter in the cerebrum, the large size of the thymus gland, of the adrenals and of the liver, and the incomplete ossification of the cranium, are all anatomical factors which must markedly influence the evolution of disease in the young.

The exact manner in which infantile pathology is affected by these physiological and anatomical peculiarities of the immature organism is a difficult subject to investigate; but with regard to some of the characters of infantile pathology information of a reliable kind is forthcoming, and with regard to others there are ever-increasing indications of the truth.

I have dissected a full-time infant which had evidently died a few days before birth from a tight knot on the umbilical cord, for mercury could be made to pass through the arteries but not through the veins. Now, had the tightening of this knot not occurred, the fœtus would in all probability have been born alive, for it was otherwise healthy. The real morbidity of the fœtus, then, may be checked or abolished by the change from an intrauterine to an extrauterine existence. This may not always, or indeed often, occur, but that it does happen sometimes is, I think, not doubtful.

This whole subject is capable of great expansion; a result which can only be accomplished by patient research and the systematic examination of stillborn and deadborn fœtuses; and the making of *post-mortem* examinations of cases of still-birth would be greatly stimulated by their compulsory registration. What Mor-

gagni said long ago is still to a large extent true. He remarked that "a wide and almost unbeaten track lies open for the investigation of the diseases of new-born infants;" and a very recent and striking instance of the truth of his statement is to be found in the appearance of such papers as that of Dr. Herbert S. Spencer on "visceral hæmorrhages in still-born children." In this contribution to infantile pathology, the prediction made more than fifty years ago by Dr. Stokes has been amply fulfilled. He said: "I believe that any one who has the opportunity of dissecting a great many stillborn children, or of those who die immediately after birth, would, by examining the state of the different cavities, and publishing the results of his examinations, earn for himself very great reputation."

#### TREATMENT OF URTICARIA.

Stern (*La Semaine Médical*, 1890) has treated successfully by iodide of potassium five cases, four of them being more or less chronic and rebellious to all previous treatment. None of the patients were either syphilitic or asthmatic. In one case, of four months' duration, the itching disappeared on the second day of treatment, and the cure was completed after two and a half drachms of the remedy had been taken. In two cases (one acute, the other chronic) the itching was at first increased, but a successful result was obtained in each case after the administration of seventy-five grains of the drug.—*American Journal of Medical Science*.

#### ANTIPYRIN IN DIABETES.

The Paris correspondent of the *Brit. Med. Jour.* writes thus of Dr. Robin's methods in the Hôpital de la Pitié:

Dr. Robin lays stress on his success in the treatment of diabetes. Accepting the views of Claude Bernard, and considering that diabetes is in the immense majority of cases the results of excessive functional activity of the liver, which is itself dependent on a nervous affection, Dr. Robin employs antipyrin, which exercises a great moderating influence on the nervous system. He lays much stress on the particular mode of use of this drug, and considers it essential for his method of treatment to determine every day the quantity of urine passed, its richness in sugar, density, quantity of urea, phosphates, and albumen.

Excessive diminution in the quantity of urine and the appearance of albumen he considers to be unfavorable, being indications of profound perturbation of nutrition. Unless the patient be carefully watched, grave accidents may occur, but if a daily analysis of the urine is made, the dose of antipyrin and the duration of its use may be regulated, and all complications avoided. A medium dose is from three to four grammes a day. It is continued for a week without requiring the diabetic patient to limit himself to a severe diet. The quantity of urine diminishes, its richness in sugar falls very considerably; sometimes, indeed, the sugar disappears, and the quantity of urea is lessened. The medicine is then left off for three weeks. At the end of this period the glycosuria never resumes its primary intensity, and considerable amelioration continues. The diabetic regimen is now discontinued, and the antipyrin renewed for a week, and then the medicine is left off, and the diabetic dietary renewed for three weeks. From three to six months of such treatment generally suffices, in Dr. Robin's experience, to reduce the elimination of sugar to insignificant proportions, and in a considerable number of cases leads to a cure of the diabetes. This cure, according to Dr. Robin, is permanent in 10 per cent. of the cases. The scientific capacities of this physician are such that it is not at all likely that he should make any error of diagnosis in these cases, and confound diabetes with alimentary glycosuria. He proposes to give a series of lectures shortly on the functional disturbance of the



liver, in which he will explain more in detail his conception of the different forms of diabetes and their treatment. Hydrotherapeutics, studied from a scientific point of view, play also a large part in his method of treatment, of which I have probably said enough to show that they are scientifically conceived, based upon serious study, and carried out with persevering ingenuity.

#### FOR TAPEWORM.

One of the best remedies for the expulsion of tapeworm from the intestinal canal is the oleoresin of male fern. After the usual preparatory treatment by low diet and catharsis, two drachms of the oleoresin of aspidium may be whipped up with the yolk of an egg and peppermint-water, and syrup added to make two ounces; the whole being taken in the morning, on an empty stomach; and; if necessary, followed by a purgative.

#### INCONTINENCE OF URINE.

R̄.—Tinct. nucis vomicæ . . . . . f ʒvj.  
 Ext. damianæ fl. . . . . f ʒijss.  
 Glycerini . . . . . q. s. ad f ʒiv.—M.  
 S.—3 j three times a day, after meals, in a wineglassful of water.

#### LOCAL ANÆSTHESIA.

At a meeting of the Berlin Medical Society, Schleich (*Berliner klin. Wochenschr.*, 1891, No. 51, p.1202) reported the successful performance of two hundred and twenty-four minor and major operations—including sequestrotomy, herniotomy, laparotomy, amputation of fingers, suture of the patella, radical treatment of hydrocele, extirpation of tumors, and nephrorrhaphy—by means of local anæsthesia. It was found that but small quantities of cocaine were required for the induction of local anæsthesia if considerable quantities of water were injected, so as to cause generous infiltration of the tissues. To obviate the pain of puncture, a spray of ether is first applied. The needle of a hypodermic syringe is then introduced, parallel with the surface, beneath the papillary layer of the cutis, endermatically, and a small quantity (three or four minims) of a solution of cocaine (gr.  $\frac{1}{10}$  to f ʒj) injected. The procedure is repeated throughout the area to be operated upon, the little nodules formed mutually touching at their periphery. According to depth of proposed incision, layer after layer of tissue is treated in a like manner, even down to the periosteum, the bone, and the osteo-medullary cavity. A two per cent. solution of potassium bromide or of caffeine may be substituted for the solution of cocaine. The essential factor in the development of the anæsthesia is the infiltration of tissue. The largest dose of cocaine required in any case in which it was employed was a little more than half a grain.—*Medical News.*

#### PELVIC INFLAMMATION IN WOMEN.

Dr. Potter, in a pathological study of this most interesting condition, which furnishes such a large proportion of the gynæcologist's work, regards McMurtry's grouping of varieties of inflammation as about the best. It is as follows: 1. Inflammation of serous and cellular intra-pelvic tissues cannot be separated clinically nor histologically, hence they cannot be properly distinguished by the terms perimetritis and parametritis. 2. The pelvic cellulitis of Emmet, which corresponds to the peri-uterine phlegmon of Nonat, is as rare as inflammation of the cellular tissue elsewhere. 3. Pelvic inflammation is, generally speaking, peritonitis resulting from disease of the ovaries or Fallopian tubes, or both. 4. Pelvic peritonitis presents every grade of activity, and is always symptomatic, never idiopathic. These inflammations are either of puerperal, gonorrhœal, or miscella-

neous origin, and under the latter are included all infections of the endometrium by instruments, medicinal agents, and traumatism.—*American Gynecological Journal*.

#### ON THE TORSION OF ARTERIES.

In connection with operations for excision of tumors, and other excisions of a like character, Jonathan Hutchinson remarks as follows: "I may mention that for many years I have quite ceased to use any other means for arrest of arterial bleeding than torsion. In excision of the breast, for instance, I do not think that I have during the last fifteen years ever used a ligature. The torsion is always effected by a pair of Well's clamp-forceps, now in such universal employment. I am always extremely careful to close all vessels, keeping the wound exposed for a considerable time for that purpose. Very seldom, indeed, have I encountered any secondary hæmorrhage."—*Archives of Surgery*.

#### ACTINOMYCOSIS HOMINIS.

In a lengthy dissertation upon this subject in the *Chicago Medical Recorder*, February, 1892, Dr. Murphy arrives at the following conclusions:

1. The growth of the disease is very indolent and sluggish, except in the peritoneal cavity.
2. It is accompanied by very little pain.
3. The microbe does not produce a ptomaine that has the effect of causing an elevation of temperature.
4. Pure infection by the actino-cladotrix is not accompanied by pus. Pus is present only after a secondary infection with the streptococcus pyogenes.
5. The amount of infiltration around each nodule of granulation and its seropurulent contents is very great compared with small contents.
6. The greater the amount of suppuration the more malignant and rapid is the progress of the disease.
7. Diffusion of the actinomyces in loco or by entrance into the blood stream are its modes of extension; never along the lymphatics and glands. Its extension is greater in opposite direction to course of lymphatics.
8. After evacuation of contents nodule heals rapidly, but in a few weeks or months reappears, if all germs were not removed.
9. Fatal symptoms are very tardy in appearing, due principally to the very great connective tissue infiltration, barring the progress of the disease.

#### TREATMENT OF LIVER ABSCESS BY SIPHON DRAINAGE.

In a communication to the *Brit. Med. Jour.*, Feb. 13, 1892, Dr. Phillips explains the method as follows:

The method of treatment employed by Dr. Bülau, although based on the same principles as Dr. Manson's, differs from the latter in some of the details, and may be preferred by some practitioners, especially as it involves no increase of the armamentarium chirurgicum. The preparations are as follows: Get an ordinary trocar of not too small a calibre, and a Nélaton catheter fitting accurately into the cannula; fenestrate the catheter according to the presumed depth of the abscess or, in empyema, of the pleural cavity; cut off the thickened rim at the distal end. Have ready a scalpel, solutions of carbolic acid (5 per cent.) and of boracic acid (3 per cent.), and a little carbolised olive oil; further, prepared cotton wool, iodoform powder, soft gauze roller, pretty stout silk ligature, elastic collodion, adhesive plaster, a few feet of india-rubber tubing, a glass funnel, a ring of lead (half an inch or an inch of ordinary leaden piping will do), two clamps, a short glass tube fitting into the catheter and slightly widened at the other end, if possible, to fit into the thicker tubing, and lastly, a glass jar to serve as a recipient.

The use of these simple articles is as follows: All necessary antiseptic precautions being fulfilled, a small incision is made in the skin, and the trocar, enclosed in its sheath, passed into the diseased cavity. Thereupon the stilette is withdrawn, the thumb of the left hand adroitly closing the orifice of the cannula until the catheter, carefully lubricated, can be passed through it into the cavity; then the sheath is withdrawn, and the catheter closed with a clamp. These manipulations must be performed rapidly so as to prevent any escape of pus. A little iodoform is now sprinkled on the wound, the lips of which close well around the catheter, and the latter is fastened to the skin of the thorax by carefully fixing a number of thin layers of cotton wool around it by means of collodion. In this way a little antiseptic shield is formed, which adheres firmly both to the catheter and the skin. In addition, the former may be tied round with a silk ligature, the ends of which are then looped and fixed with adhesive plaster or strips of gauze and collodion to the thorax, or the adhesive plaster may be fastened direct to the catheter. If the whole is then enveloped in cotton wool a perfectly reliable dressing is secured. The connection with the siphon is made in the following manner: The recipient is partly filled with antiseptic fluid; the glass funnel is weighted with the leaden ring, and the stem inserted into one end of the tubing, the other end being joined to the piece of glass pipe; the tubing thus fitted is filled with solution of boracic acid, and firmly connected with the projecting end of the catheter, the glass funnel is placed stem upwards in the recipient, a little dexterity being required to prevent air getting into it while so doing. When this has been satisfactory achieved the clamps are removed, and a steady flow of pus is at once established.

Although fully recognizing the advantages of Dr. Manson's method of proceeding, I have here ventured to recommend the German plan, which, from fairly extensive personal observation, I can state to be safe, efficient, and rapid of execution.

#### THE BRAIN IN INFLUENZA.

In the *Lancet*, February 20, 1892, Dr. Goodall reports that during the spring and early summer of last year the brains of thirteen cases dead of influenza and its pulmonary complications were examined in the West Riding Asylum. The results may be stated as follows with strict regard to the morbid conditions specified above: 1. The arteries at the base are described as "healthy," "normal," and "atheromatous;" there is no mention of congestion. It is quite improbable that congestion in a remarkable degree should have escaped notice and record. 2. In two cases the "internal membranes" are described as "congested," in one as "perhaps congested." In two others it is stated that the pia contained but little blood. In the remaining cases the lepto-meninges were either normal or showed the changes of chronic brain disease (thickening, opacity). As regards hyperæmia of the brain itself, one case showed "much injection of grey and white matter throughout," and "the internal capsules were notably injected." In another the grey matter was "slightly congested." In a third the white matter was "congested in the posterior part of the brain." In two other cases the brain is described as "pale." In the remaining cases the color was the average. 3. There is no note of increase in consistence in any of the cases; in nine the brain is said to have been of "reduced consistence." 4. No pachy- or lepto-meningitis in any of the cases. Lastly, if we take (as Dr. Althaus does) the state of the arteries at the base of the brain as a criterion of the vascular condition of the medulla oblongata, it may be inferred that no congestion existed in this organ in these cases, an inference which may be drawn with the greater confidence in view of the fact

that the bulb is invariably examined in every necropsy held here. It is therefore extremely improbable that noteworthy congestion would have escaped detection. Apart from the testimony of the records, I am informed by my colleagues, who made the examinations, that they have no recollection of remarkable hyperæmia in any of these cases, whether at the base of the brain or elsewhere.

IRRITABLE BLADDER.

R.—Potassium citrate,	.	.	.	gr. iv.
Fluid ext. triticum repens,	.	.	.	.
Tinct. of hyoscyamus,	.	.	.	aaʒj.
Fluid ext. of buchu,	.	.	.	ʒss.
Water, sufficient to make	.	.	.	ʒiij.

M. Sig. One teaspoonful in a wineglassful of water, three or four times daily.—*Ex.*

Medical Items.

The St. Louis Medical College, which was lately made a department of Washington University, is to be housed magnificently. The new building, exclusive of the site, is to cost \$107,000.

There are 147 universities in the world, of which the largest is in Paris, with 9,215 students; the next in Vienna, with 6,220; the third in Berlin, 5,527. The smallest is a branch of Durham University, Fourah Bay College, in Sierra Leone, with twelve students and five professors.

Antipyrin is put forward by M. Gunde, who claims for it a place amongst the best remedies in the therapeutics of incontinence of urine in children. He administers it in wafers containing from seven to fifteen grains, or in a mixture. This latter may have from twenty to sixty grains.

Georgia is going to tax bachelors. A bill for that purpose has been brought into the Georgia Legislature, and the House Committee on hygiene and sanitation has reported it favorably. Under its terms it will cost a Georgian \$25 to begin the bachelor business at thirty years of age, and on a rising scale of \$25 for five years a man of sixty and over will be at the expense of \$200 per annum for the privilege of going without a wife.

The annual mortality of the entire human race amounts, roughly speaking, according to a French medical journal, to 33,000,000 of persons. This makes the average deaths per day over 91,000, being at the rate of 3,730 an hour, or 62 people every minute of the day and night the year round. A fourth of the race die before completing their eighth year, and one-half before the end of the seventeenth year; but the average duration of life is about thirty-eight years. Not more than one person in a hundred thousand lives to be a hundred.—*New York Sun.*

Dr. Stephen Mackenzie, in the *British Medical Journal* for February 13th, reports a case of intermittent fever in which twice the temperature was 107° F., once 109°, twice 113°, and once 113.8°. The observations were made with the thermometer in one or the other axilla; sometimes two thermometers were placed in the axilla and found to correspond. On account of rigors the temperature could not be taken in the mouth. The periods of hyperpyrexia were exceedingly brief, sometimes a return to normal temperature occurring in five minutes. The patient recovered.

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## CONTENTS

### ORIGINAL ARTICLES.

- Some New Studies of the Opium Disease. By  
T. D. Crothers, M. D., Hartford, Conn. . . . . 419
- Infant Foods other than Breast Milk. By A. K.  
Bond, M. D., Baltimore. . . . . 425

### SOCIETY REPORTS.

- Gynæcological and Obstetrical Society of Balti-  
more. January Meeting. Dermoid Cyst. Twin  
Pregnancy, Complicated by Placenta Previa  
Centralls. . . . . 428

### EDITORIAL.

- The Recording of Clinical Cases. . . . . 431

- The Code of Ethics. . . . . 432

- A Plea for Contributions. . . . . 433

### HOSPITAL REPORTS.

- Annual Report of the Presbyterian Eye, Ear  
and Throat Charity Hospital for 1891. . . . . 433

### MEDICAL PROGRESS.

- Aniline Injections for Hopeless Cancer.—Phe-  
nocoll Hydrochlorate.—Treatment of Chorea  
by Exalgine.—After-Treatment in Surgery.—  
A Difficult Face Presentation. . . . . 435

- MEDICAL ITEMS. . . . . 440

## Original Articles.

### SOME NEW STUDIES OF THE OPIUM DISEASE.\*

BY T. D. CROTHERS, M. D.,

Superintendent Walnut Lodge Hospital, Hartford, Conn.

As a preface, I wish to express my emphatic dissent against the common use of the word *habit*, in describing the opium disease. The popular meaning conveyed by this term is some state or condition voluntarily acquired and retained with the certainty of being thrown off at any time at the will of the patient. This view assumes a knowledge of the physiology and psychology of the brain and its functions that is not yet attained. Hence the use of the word is incorrect, wrong and contradicted by the facts in the clinical history of each case. It also conveys a false impression of the nature and origin of such cases and is a word to which different meanings will always be given. No other word is more misleading and confusing, when applied to opium, alcohol, and other border-land neuroses.

Beyond all question, the toxic use of opium and its alkaloids is rapidly increasing. Only about 50 per cent. of the opium and morphine manufactured is required by the legitimate demands of medicine and pharmacy. The enormous balance is consumed in some unknown way. Comparative estimates make the number of opium cases in this country over a hundred thousand. Whether this is correct or not, it is evident that the number is very great and largely concealed, and many of them are very hopeless and difficult to treat. The natural history of such cases indicates a steady, progressive degeneration, on to death. Recovery is rarely

\*Read before the Philadelphia County Medical Society, January 27, 1892.

spontaneous, and without the aid of applied science. Up to the present all clinical studies have been confined to the symptoms and treatment, starting from some indefinite point after the opium addiction begins. The old superstition of a moral origin, and of some wilful, wicked impulse, is accepted as the first original cause. Writers, and even specialists, seldom go back into the early etiology, or inquire what conditions or forces led to the first use of opium. The object of this paper is to trace some recent facts which throw new light on this unknown stage of etiology.

From a careful clinical study and grouping of the history of a number of opium cases, it is evident that a large proportion have a distinct *neurotic diathesis*, or, more literally, have inherited from their parents some condition of brain and nerve defect which favors and predisposes to the development of neurotic diseases. A more careful study of these records shows that in some cases an *opium diathesis* is present, or a special inherited tendency to use opium. Here are two conditions which influence and favor this disease. It is a well known fact that a large proportion of all nerve and brain diseases appears in children of neurotic and defective parents. Such children have received some special tendency and predisposition favoring the growth of nerve diseases, springing into activity from the slightest causes.

The latency or activity of this diathesis will depend on certain conditions of life and surroundings, which in many cases can be traced. In some instances the diseases of parents reappear in the children, in others in allied diseases, and not infrequently these defects pass over and reappear in the third generations. Often such defects are dormant, and only break out from the application of some peculiar exciting cause. Thus a hysteric mother and paranoiac father were followed by three children. One was an alcoholic, the second was a wild, impulsive temperance reformer, the third was a sad, depressed, melancholic man. In the third generation opium and alcoholic inebriety, insanity, pauperism, also feebleness of mind and body, appeared. These varied forms of nerve diseases all had a neurotic diathesis as a basis, and the different phases were the direct result of different exciting causes. These facts are numerous and well attested, and so uniform in their operation that it is entirely within the realm of possibility to predict that, from a knowledge of the diseases of the parents and the environment of the child, certain forms of degeneration and disease will appear with almost astronomical precision. This term neurotic diathesis covers a vast unknown field of causes which extends back many generations. The evolution of brain and nerve defects can often be traced through the realms of environment, nutrition, growth, and development. Medical text-books and teachings which fail to recognize this give very narrow conceptions and strange exaggerations of the influence and force of many insignificant and secondary factors in the production of disease. The opium-taker has often this neurotic element in his history. It may be traced back to his ancestors, or it may be associated with brain or nerve injuries, cell-starvation, faulty nutrition, auto-intoxications, brain strains, or excessive drains of nerve force. A train of predisposing causes may have been gathering for an indefinite time back. Then comes the match which kindles or fires the train of *gathering forces*. This same train of exciting causes may not explode, because the germ soil is absent. Opium in all forms is given daily, and yet only a comparatively small number of cases become addicted to its use. Why should an increasing number of persons take opium continuously for the transient relief it gives? Why should the effects of this drug become so pleasing as to demand its increased use, irrespective of all consequences? The only explanation

is the presence of a neurotic diathesis, either inherited or acquired. The existence of a special opium diathesis has been doubted with supercilious contempt by many writers. Any clinical study of cases will show the error of such doubt.

There is a large class of opium cases in which a complex diathesis exists—particularly following inebriety and various forms of brain exhaustion. Often alcoholics will use opium irregularly and transmit to their descendants a diathesis which very commonly favors the use of this drug. Thus the alcohol diathesis frequently becomes the opium craze, with but slight exposure. Both of these disorders are rapidly interchangeable. The children of opium-takers may turn to alcohol for relief, and *vice versa*. It is clear that the moderate use of alcohol produces a degree of degeneration that frequently appears in the next generation as predisposing causes to the opium or allied diseases. Clinical study of cases brings ample confirmation of this. The children of both alcohol and opium inebriates display many forms of brain degeneration. The paranoiacs, criminals, prostitutes, paupers, and the army of defects, all build up a diathesis and favoring soil for the opium craze. Descendants from such parents will always be markedly defective. They are noted by brain and nerve instability, hyperæsthesia, and tendency to exhaustion; also extreme pain from every degree of functional disturbance, with low powers of restoration, inability to bear pain, and suffering from mental changeability, impulsiveness and drug credulity, etc.

These characteristics are prominent, and mark a neurosis that quickly merges into the opium disease. Yet a minority of these cases show a sensitiveness in the effects of opium that prevents them from using it. I have seen a neurotic patient become dangerously narcotized by the use of half a grain of solid opium. Some of the alcoholics and other narcomaniacs have exhibited an incompatibility to opium that is often startling. The emesis and prostration, and the brain-stimulation which approaches and becomes hyperæmia from one or more doses, are familiar to all. This intolerance precludes the use of the drug, and is recognized with alarm by the patient. On the other hand, when the effects are rapid and marked, relieving pain or restoring the disturbance of the functions with no other than a pleasing sense of rest and cure, a dangerous diathesis should be expected. While the physician recognizes the constitutional incompatibility in one case, he ought not overlook the abnormal attractiveness of the drug in the other. The dose of morphine which gives the first complete rest, or calms the delirious excitement, or relieves the neuralgic pain or the digestive disturbance, soon calls for its repetition, and many physicians will unconsciously sanction and advise its use. Thus, far more fatal conditions are cultivated and roused into activity. In all neurotic cases, the use of opium in any form, when given, should be concealed and watched with care. If a special predilection for this drug appears, equal care and skill should be exercised to divert and change it. Opium should only be used from a knowledge of the nature and character of the case. I have seen the most disastrous results from the reckless use of morphine with the needle. Recently, a man to whom morphine was intolerant was cut and stunned by a falling plank in the street. The surgeon gave him a hypodermic of morphine and ordered him to the hospital. He died in a short time from opium neurosis. Police surgeons often make this mistake, giving morphine that from some unknown reason becomes fatal.

There is another class of opium-takers in which abnormal nutrition seems to be the most active factor in the causation. The neurotic or opium diathesis is not apparently present, and opium-taking dates from some nutrient disturbance. Such cases are very commonly sufferers from dyspepsia, derangement of the liver

and bowels. They have a deranged appetite, headaches, cramps, thirst, and fever at times, with nausea. They are anæmic and hyperæsthetic, and complain of varied pains and neuralgias. These cases are evidently ill-nourished, and, in all probability, suffer from imperfect digestion, assimilation, and elimination of food products and waste material. Poisonous compounds and auto-intoxications form sources of serious trouble. The brain suffers from fatigue and pain, the cells are imperfectly nourished, and congestions, complex neuralgias, nerve irritation and instability follow. For this condition opium is almost a specific paralyzant. These cases are found among the over-fed, the under-fed, and those who neglect common hygienic rules of living. Cases of over-fed are usually epicures, gormands, and persons living sedentary lives, and eating at all times and places. Dyspepsia and derangement of the bowels and kidneys make them drug-takers; then follows opium in some form. Defective elimination and auto-intoxications are always present. The under-fed are usually misers or persons very poor and very neglectful of themselves, or paranoiacs who have some food delusion. They are practically suffering from cell and tissue starvation and nutrient debility. The dyspepsia and bowel derangements follow. Then follows drug-taking or special foods, and soon opium is discovered and adopted as a remedy. The same poisonous waste-products appear from deranged assimilation; also, elimination and the nerve centres are deranged by these new and dangerous chemical compounds. The class of persons who, from simple neglect, become diseased, are often the very poor and ignorant, or some division of the great army of borderliners, who live both mentally and physically on the frontiers of sanity and insanity. Such persons clearly suffer from many various forms of auto-intoxications, and this is proven inductively by the result of the eliminative treatment. In all of these cases of nutrient neglect, many favoring conditions encourage the use of opium. These cases are numerous and comprise a large part of the invalids, hypochondriacs, and chronic drug-takers who are seen in other offices and at the dispensaries. They are all practically suffering from faulty assimilations, and faulty eliminations and the irritation of retained poisonous compounds. Opium is a remedy of positive force in covering up the protests of the defective cells and irritable nerves. Often these cases are concealed and are partly the result of previous disorder, and partially acquired from the effects of opium.

Next to this class of nutrient sufferers who become opium-takers, are those who have some entailment of disease or injury. In their history it will appear that some stage of invalidism was present, dating from brain, nerve, or bodily injury. Fevers, heat, or sunstrokes, brain shocks from any source which are followed by unconsciousness, or marked mental perturbations, with exhaustion, and also a profound lowering of all the vital forces. These and other events have left damaged functional and organic activities, manifest in various neuralgias and physical disturbance.

The use of opium conceals and covers up this trouble. Many veterans of the late war have become opium maniacs for the relief of their pains and sufferings, and this is often concealed where it might possibly peril the procuring of a pension. The pension bureau should recognize the use of opium as a natural sequence and entailment following the disease and injury in the service. In Prussia both alcohol and opium inebriety are treated as diseases when occurring in the civil service or army. The suffering and hardships growing out of the war has been the exciting cause of a great many opium cases. Many persons who have no special nerve diathesis in their history, after some severe illness, injury, or mental strain exhibit a degree of nerve instability and feebleness that is sig-



nificant of serious organic change. Such persons manifest perversions of taste, with delusions of foods and medicines, and are on the border-lines of narcomania, ready to use any food or drugs which will bring even transient relief. The use of opium is always perilous. Why all these and similar cases do not become opium-takers, is owing to the absence of some diathesis inherited or acquired.

We can see some of the many complex causes favoring brain and nerve strain, with rapid exhaustion and degeneration, and the interchangeability of nerve diseases, in which the use of opium is only another form of the same disease. But we cannot yet trace the early causes and cell-conditions which develop the opium craze. This morbid impulse, like the delirious thirst for water on a desert plain, completely dominates all reason and so-called will-power, and every consideration of life and surroundings. It is more than an accident, more than a failure to reason and act wisely; it is a disease, an organized march of dissolution. The demand for opium is only a symptom; the removal of opium is not the cure. Some central brain-degeneration has begun and is going on. Narcomania, a morbid thirst for any solids or fluids that will produce neuroses, is the general name, and opium mania is only one member of this family.

In this study the fact is emphasized that the opium disease appears most frequently in persons who have a neurotic and opium diathesis, and also in persons who are suffering from nutrient disturbances, and those who are invalids or have some entailment of previous disease and injury; also that certain diseases and symptoms seem to furnish favoring soils for its growth and development. While these are but faint outlines of many unknown facts, they are urged as starting-points from which to base other and more accurate studies. The medical treatment from this point of view is very suggestive. Obviously the removal of the opium is not the cure. The various methods of removal detailed with great exactness, as if they would apply to each case, are unfortunate reflections of the failure of the writers, and are based on the assumption that all cases are the same, and the removal of the opium is the great essential in the treatment. Basing the treatment on the clinical study of the case, it will be evident that where an opium diathesis exists, the withdrawal of opium should be very gradual. The treatment and surroundings should be arranged with great care and exactness. Such persons should live in an institution for years, or be under constant medical care. The danger of relapse and the future of such cases will depend entirely on the conditions of life and surroundings. Rapid reduction and any heroic treatment is never permanent, even with the consent of the patient. Specifics, faith cure, or any measures that promise speedy cure, are failures from the beginning. The road back to approximate health is straight and narrow, and only along lines of applied science. Where the history of a *neurotic diathesis* is present, the withdrawal of the opium should be equally slow.

More attention must be paid to the brain and nerve nutrition. The removal of opium may be followed by the appearance of very serious disorders, such as epilepsy, hysteria, complex neuralgias and paranoiacs phases, alcoholism, and various other neuroses. The slow withdrawal of opium enables one to discover and anticipate these neurotic troubles which have been masked before. In one case, suicidal melancholy; in another, hyperæmia of the brain, with delusions; in the third, irritation and delirium; in the fourth, hysterical spasms appeared when the opium was removed. I have seen two cases of general paralysis suddenly spring into great activity, after the opium was taken away. This condition was not suspected before. Alcoholism is a very common sequel after the removal of the opium. *Cocaine, chloral*, and almost every drug that has narcotic properties are also very

common entailments. While these are extreme cases, they are likely to be formed at any time. Great care should be exercised in using other narcotics to lessen the irritation from the withdrawal of this drug. Foods and tonics should be given. These cases require the same general treatment as neurasthenia and other states of brain exhaustion. They are drug takers and will resort to anything for relief. They are secretive, and require more care and more mental remedies, with long, exact hygienic surroundings.

Where the opium addiction has apparently come from bad nutrition and faulty elimination, with auto-intoxication, the treatment is very hopeful. A long preliminary course of baths, mineral waters, and tonics should precede the removal of opium. Then the opium may be removed at once, without the knowledge of the patient. In proper surroundings with frequent baths, little danger of relapse or suffering will follow. Careful study and treatment of nutrition and digestion will fully restore the case, and relapse seldom occurs except from failure or neglect of the surroundings.

In the last class, where opium is taken and apparently follows from the entailment of some disease or injury, or the exhaustion of old age, a preliminary period of treatment seems to be required. Often the opium can be abandoned at once for some milder narcotic, and from this, by gradations, discontinued entirely. Full knowledge of the diseased states present will always suggest the lines of treatment. In some cases, the opium should not be removed; its diminution and concealment is required. In others, its rapid removal is essential. Many varied and difficult questions will appear in these cases. The more accurately the diseased states, also predisposing and exciting causes, the diathesis, and varied influences which have caused opium to be used, are studied, the more accurate the treatment. As in many other diseases, the causes may be anticipated, also neutralized and prevented. Opium-taking should be seen as a symptom; remove or break up the cause, and this symptom disappears.

Routine treatment, either by slow or rapid reduction of the opium, is not wise. The substitution of other narcotics is equally unwise. In a certain number of cases the withdrawal of opium only unmasks more serious diseases, and is positively wrong. A case of general paresis is now under treatment for opium addiction. Before this opium addiction began the patient caused great distress by his delusions and extravagantly strange conduct. This treatment is wrong. A rheumatic woman of seventy is going through the same course to be free from opium, which has made life tolerable for ten years past. The treatment of opium mania is something more than the application of means and remedies for withdrawal of the drug with the least suffering. The symptomatology and organic lesions often date back to other causes more complex than opium. The treatment must begin by their removal. The general or special diathesis must be treated; the nutritive disorders, intoxications, and starvations must be recognized and removed. The influence of pathological states from previous disease and injury must be ascertained and treated. The power of environment, climate, occupation, and idiosyncrasies are also powerful factors to be considered.

These are the essential facts and conditions which must enter into the practical treatment. Among the many important problems, that of prevention promises the greatest possibilities. A recognition of the neurotic diathesis and other predisposing causes would enable the physician to successfully guard against its approach.

The successful *stamping* out of both this and the alcoholic disease will be a reality in the future.

It is evident that the opium disease is still an undiscovered country, and the few student experts have not yet passed beyond its frontiers. This disease is all about us and may invade our homes and firesides any time, and *hence* demands recognition and most careful study; above all, ethical and moral levels. Its laws of growth, development, treatment, and curability all follow the great highway of evolution and dissolution.

## INFANT FOODS OTHER THAN BREAST MILK.\*

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children in the Baltimore Medical College.

Gentlemen:—When breast milk of proper quality and in proper quantity cannot be furnished to the young infant, we are accustomed to seek a substitute in the milk of the cow.

Cow's milk, even when obtained from healthy cows, is in its natural state unsuited for the digestion of the young infant.

*First*, because of fermentative changes which may be produced in it by germs received from the atmosphere or from other sources during transportation, especially in the hot months of the year.

The destruction of such germs and the prevention of further fermentative changes is best accomplished by

### STERILIZATION

of the milk. It is well known that prolonged heating at or near the boiling point will either destroy or for a time restrict the activity of most forms of germ life. It is also well known that germs from the atmosphere cannot enter a bottle which is closed with a stopper of raw cotton. Sterilization consists in the heating of the milk, in bottles closed with cotton stoppers, for half an hour or an hour, in a vessel containing water which is kept at the boiling point. If the stoppers of cotton are left in the bottles the milk cannot ferment even if kept for days in the heat of summer.

I show you here a very neat apparatus for sterilization, kindly furnished me by Messrs. Hynson and Westcott, 421 N. Charles St. It consists of a tin kettle with lid, and a wire cage which holds eight nursing bottles. The cage stands on feet which raise it an inch above the bottom of the kettle. The water does not reach as high as the bottles and so the milk is sterilized by steam heat. After three-quarters of an hour heating the milk is allowed to stand in the closed bottles and when needed the cotton is removed and a rubber nipple put on. The milk is properly diluted and sweetened before it is put into the bottles. By this apparatus the supply of milk for the whole day is prepared at one time. The cotton must be clean and pure.

The objection to sterilized milk is that the milk is not rendered in any respect more digestible; but on the contrary there is reason to believe that certain desirable properties of the milk (known as "antiscorbutic") are lost in consequence of prolonged heating.

It was at one time believed, during the first flush of the "germ era" the summer complaints of infants were due to germ action in the intestinal tract, and when germs were shut out, as by an exclusive diet of sterilized or breast milk, such diseases could not occur. I was myself carried away for a time, but experience and

\*Being a clinical lecture, delivered to the class February 20th, 1892, somewhat amplified.

reflection have taught me better. The causes of summer complaints are numerous and their modes of action are still very obscure. The best we can do is to have the infants' food as pure and sweet as possible—germ or no germ.

#### CONDENSED MILK

represents another effort after the supply of a pure milk of constant composition. It is prepared by evaporation of sweet milk from carefully selected cows. Its advantages are that it furnishes a pure sweet milk upon dilution of the contents of the can with warm water and that it is always at hand, ready for use. Its disadvantages are: that it contains, as a preservative ingredient, a larger proportion of cane sugar than the child can safely assimilate; that it has much less fat in it than mother's milk; and that it probably lacks the "antiscorbutic" properties.

Although many infants thrive on condensed milk, I am convinced that I have been called to babies who were starving upon it. The lack of fat may be met by the addition of cream at the time of nursing. "Preserved" milk is said not to contain an excess of cane sugar, but it is not yet commonly sold in the markets. My assistant will now pass round for your inspection Blair's condensed milk, from a sample package sent me by H. C. Blair's Sons, Eighth and Walnut Streets, Philadelphia. There are many excellent preparations in the market, one of the best being the "Eagle Brand."

*Second*, cow's milk is difficult of digestion by the infant because the proportion of casein—matter requiring digestion—is too great.

This difficulty is met by simple *dilution* with an equal quantity of warm water—more or less, according to age; or by the use of

#### CREAM MIXTURE,

a mixture of *cream* and water. Dr. Woollen (Mother's Hand-book; Everett Waddey Co., Richmond, Va., 1891) says: "Take one part of fresh country cream and add to it ten parts of hot water, in which one even teaspoonful of white sugar for each gill of water has been dissolved. This should be stirred until well mixed, and fed warm, to the amount of a gill every two or three hours."

*Third*, the last but most serious objection to the use of cow's milk for infants is that the casein of cow's milk coagulates in the stomach into large, dense, indigestible curds; whereas the infants' organs are adapted only to the digestion of the small flaky coagula of breast milk. This difficulty is met in two ways:

I. By predigestion of the casein of the cow's milk,

#### PEPTONISED MILK,

so that before it is taken by the child a large part or all of its casein is converted into more soluble substances (peptones, etc.), which require little or no digestive efforts on the part of the infant. For this purpose pepsin and pancreatin are employed, being added in powder (or liquid form) to the milk and warmed with it just before administration. The action of the ferment is favored by the heat. When the milk is supposed to be sufficiently modified the ferment is rendered inactive by heating for a time to the boiling point.

This would seem an ideal method, but certain objections are urged against it. The busy mother has not always leisure to observe with necessary accuracy the directions for peptonizing; certain variations in the heating will cause a bitter taste in the milk (which however is said not to be noticed by infants); and further, there is the standing objection against predigesting food—that the stomach thus fed may after a time lose its power of digesting for itself.

I pass round for your examination some peptonized milk, which we have just prepared with a sample of Peptogenic Milk Powder sent me by Fairchild Bros. & Foster, of New York.

II. By the introduction of some nutritious substance which will mechanically prevent the massing of the coagulated casein into large tough curds. The simplest class of these preparations is represented by the old-fashioned

#### BARLEY-WATER AND MILK,

which is prepared by washing two ounces of barley; boiling it then in half a pint of water; throwing away this water and adding four pints of boiling water; boiling this down to two pints, straining and mixing it with the milk in proportions of two-thirds, half, or more, according to age.

Another such home-made food is

#### TOASTED CRACKERS AND MILK.

To prepare this some fresh cream crackers are to be browned in a hot oven without burning, then grated into powder. A desertspoonful of this powder is to be put into four ounces of water and brought to boiling with stirring. As soon as it begins to boil it is to be removed and mixed with two ounces of fresh milk, agreeably sweetened. Here the cracker-dust, made more digestible by browning, serves to prevent tough and massive coagulation.

Gelatine and arrow-root were among the mechanical attenuants used by old-time physicians; as in

#### MEIGS' FOOD,

which was originally prepared as follows, by the famous Philadelphia teacher and author, J. Forsyth Meigs. "A scruple of gelatine (or a piece two inches square of the flat cake in which it is sold) is soaked for a while in cold water, and then boiled in half a pint of water until it dissolves—about 10 or 15 minutes. To this is added, with constant stirring and just at the termination of the boiling, the milk and arrow-root, the latter being previously mixed into a paste with a little cold water. After the addition of the milk and arrow-root, and just before the removal from the fire, the cream is poured in, and a moderate quantity of loaf sugar added. For a healthy infant of the first month I direct from three to 4 ounces of milk, from half an ounce to an ounce of cream and a teaspoonful of arrow-root to a half pint of water. For older children the quantity of milk and cream should be gradually increased to half or two-thirds milk and from one to two ounces of cream. I seldom increase the quantity of gelatine or arrow-root." This has been variously modified since the publication of Dr. Meigs first book on diseases of children; as by the omission of the gelatine and the addition of lime-water.

The time-honored

#### FLOUR-BALL METHOD

is both simple and interesting. A pound of good wheat flour is tied in a muslin bag and boiled for ten hours in water. Upon removal, the flour will be massed into a firm ball which is covered outside with a thick rind of dough, within which is a dry, white mass. This core is to be grated and rubbed with milk, added gradually by the tablespoonful, until first smooth paste and then a creamy mixture is obtained. Pour this into a half pint of hot milk and stir well. For a child under one year dilute the milk with one-third water. The flour-ball is to be used only morning and afternoon. The flour in the core of the flour-ball is changed by the long boiling into a more digestible substance, which when mixed thus with the milk acts both as a food and as a preventive of hard coagula in the milk. The flour-ball which I present for your inspection was prepared yesterday in the manner described. One is very much surprised on cutting open the ball

of dough to find a dry, hard, powdery mass inside. Why this difference exists between the condition of the superficial and deeper layers, I do not know. You may examine for yourself the liquid food made by rubbing the core of this ball with milk.

(Concluded in our next.)

### Society Reports.

#### GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

##### JANUARY MEETING.

The President, Dr. Wm. E. Moseley, in the chair.

*Dr. T. A. Ashby* exhibited a specimen of a DERMOID CYST which he had recently removed from a single woman 25 years of age. The cyst grew from the left ovary and had been diagnosed as ovarian cyst. It measured  $4\frac{1}{2}$  by  $5\frac{1}{2}$  inches in diameter. Its removal was accomplished without trouble and the patient made a prompt recovery.

The interest in the case centered in the character of the cyst and its contents. It was lined internally with dermal tissue, and at one point the layer covered a small piece of bone. At this point a long twist of hair grew from the skin and measured thirty inches in length. The cyst contained a large collection of sebaceous and oily matter, and large strands of hair disconnected from the tumor and matted together in the cyst.

The specimen is an uncommon variety of dermoid cyst. A similar case has been reported by Dr. Mundé, of New York. Dr. Ashby referred briefly to the origin of dermoid tumors.

They are no doubt due to an eccentric and irregular development of the epiblastic layer of the tissues of the fœtus in very early embryonic life. The cysts are almost uniformly found in organs and tissues which owe their origin to the layer of the epiblast, and this circumstance goes to explain the peculiar features which they present. The ovary is a very common location for them and this fact would tend to prove that the organs of generation originate in the epiblast.

*Dr. Wilmer Brinton* read a paper on TWIN PREGNANCY, COMPLICATED BY PLACENTA PREVIA CENTRALIS.

I was summoned at 3.30 o'clock on the morning of September 1st, 1891, to see Mrs. B. T. M. Her second confinement, from her reckoning, would take place October 15th.

I did not see her until sent for, as stated, on the morning of September 1st. Upon arriving at her home, I found my patient in bed with the history of being awakened sometime before I was sent for, by having sharp pains, which were followed by a profuse hæmorrhage. Upon examining Mrs. M., I found the vagina filled with large clots of blood, the os slightly dilated and very soft, and a placenta presenting. At this time, her pains having ceased, I cleaned out the clots from the vagina, and found the bleeding had stopped. I determined to return home, which I did, leaving orders for my patient to remain quiet, and to send for me at once if the pains or bleeding returned. I was informed before leaving the house, that a week previous the patient had had quite a severe hæmorrhage, and knowing I was out of the city, Dr. W. J. Jones, who lives in the immediate vicinity, was sent for. He saw her twice, and under the treatment and advice which he gave her, the bleeding ceased. At 6.30, or about three hours from the

time I left the house, I was again sent for. I immediately responded, and I was soon joined, at my request, by my colleague, Dr. Crouch, and by Dr. J. H. Robinson.

A vaginal examination made at this time found the vagina filled with blood, which was continuing to flow. The os was more dilated and dilatable than it was at my previous examination, and a more complete examination found the placenta presenting, which was of the most complete central variety which I have ever seen. In running my finger around I found the placenta was completely attached to the mucous membrane of the lower segment of the uterus with the exception of a small space on the left side, from which the bleeding came, in which a tear had taken place during the recent contractions which had severed a small portion of the placenta from the attachments. My opinion being verified by the gentlemen present and as the hæmorrhage and pains were continuing, we determined to deliver at once. Chloroform was administered, and introducing my hand I found the cervix not well dilated, and had some trouble in introducing my hand. I tore rapidly through the placenta at the left side and found a child presenting vertex. I ruptured the bag of water and delivered it living by podalic version. In my effort to do this, I was made conscious for the first time that the uterus contained a second child; so, tying the cord of the first child, and handing it to Dr. Crouch, who was ably assisting me, I introduced my hand for the second time and found the second child presenting shoulder, "*dorso-anterior position*" the head being to the mother's left. I turned and immediately delivered a second living child, after which I introduced my hand into the uterus and removed the placenta, which presented a very ragged appearance from my efforts made in passing it at its attachment to the uterus on the left side. After removing the placenta, the vagina and uterus were thoroughly washed out with warm water, during which I discovered the cervix was lacerated on both sides, due no doubt to my efforts to deliver the children through an imperfectly dilated cervix. Although a large amount of blood was lost during the operative procedures, the woman rallied well from the chloroform, the uterus contracted well, and our patient within a few hours presented no special traces of the severe ordeal which she had passed through. The children, both males, presented the appearance of having advanced to the  $7\frac{1}{2}$  month's utero-gestation and for two or three hours after birth did well, but later on in the day their extremities became cold, lips blue, heart weak, and they died some seven hours after their birth. The mother did fairly well for about one week, although the pulse and temperature were somewhat above normal; the pulse averaging between 90 and 100, the temperature being about 100. She sat up on the 11th day, and on the following day I was sent for and found her with a high temperature and rapid pulse, with some indication of "*phlegmasia alba dolens*" and for three weeks she was under my constant care, with evidence of well marked septic complications, and as soon as the tendency toward phlebitis disappeared in one leg it appeared in the other.

I am satisfied the late septic complications occurred from the lacerated cervix, which healed up kindly on the right side, but not so on the left, which healed slowly by granulations.

Upon my recall to the case on the 11th day, I took charge of the vaginal injections myself. Previous to this time I had entrusted this to the nurse, much to my regret, for upon my first examination I was satisfied they had not been thoroughly given; so every day for several days I introduced a speculum and with an ordinary piston syringe I washed out the uterus, the cervix and vagina with bichloride or carbolic acid sol., and dusted the seat of laceration with either

boracic acid or iodoform. Internally was given quinine, phenacetine, large doses of iron, and good food.

The leg was bandaged from time to time with an ordinary roller bandage. Greatly to my relief my patient finally recovered and seven weeks after her confinement returned to her home in Washington.

My object in reporting this case is to impress on the minds of physicians the importance of not temporizing when they have to do with a case of placenta previa. There is no safety for the mother as long as she remains undelivered. I am satisfied no one can lay dogmatic rules in every individual case, but my own personal experience has taught me that in performing podalic version, and delivering either rapidly or slowly, as the case may indicate, you are working for the best interest of the mother and child in the vast majority of cases.

*Dr. Wm. P. Chunn:* I have seen but two cases of placenta previa. One I saw with Dr. Neale. The patient had been tamponed with cotton. He took out the cotton, inserted his left hand, and delivered the child by podalic version. Both mother and child did well. I had one patient of my own. It was a marginal implantation, and I thought I could use the forceps better than turn, and I did so. I had some difficulty in getting the forceps on and failed at first, but the attending physician forced the head firmly down by external pressure, the forceps were put on and the child delivered. I think I might have done better by podalic version.

*Dr. Brinton:* There is no absolute law for the treatment of placenta previa. In my first case the patient was lost by delay. In another case the woman had bled considerably, but about the time I was called the head came down, and the bleeding stopped.

Forceps were put on and the child delivered. I am now satisfied that the first patient could have been saved by prompt action.

In the ten cases of placenta previa which I have seen in practice only two of the children have been saved. The mothers have all recovered with the one exception as specified above.

*Dr. T. A. Ashby:* I think Dr. Brinton did the proper thing in this case. My experience with these cases has been limited, having seen but two. In one the child was born dead. The mother recovered. The placenta was attached over the entire cervix and had to be torn away before the child could be delivered.

In the second case I removed a dead fœtus of five or six months with placenta previa. She had been bleeding for some weeks. She recovered and subsequently gave birth to a living child. More recently I delivered her of another dead fœtus.

With reference to the septic trouble which the Doctor's patient had suffered from, I am satisfied that lacerated cervix is a prolific cause of pelvic troubles, and I frequently find laceration of the cervix and involvement of tubes associated.

The treatment that the Doctor suggested of going into the uterus and washing it out thoroughly is very good. My own method is somewhat different. I put in a speculum, fill up the vagina with a bichloride solution and then with some cotton on an applicator remove all the debris from the cavity of the uterus. I have treated eight cases in this way in the last year and in each case got a good result.

I have seen but one case of pure septicæmia and that came on four weeks after confinement. There were no local lesions and there was nothing in the uterus to be removed. The symptoms came on the twenty-first day after confinement, and she died in about a week.



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BALTIMORE, MARCH 12, 1892.

**Editorial.****THE RECORDING OF CLINICAL CASES.**

At this season, when hosts of new-made physicians are about to begin the active practice of medicine, when the medical teacher is nearly through with the absorbing duties of the college session, and when the family physician has a little respite from the treatment of winter diseases, preparatory to the onset of summer complaints, it is well to pause and form new resolutions in regard to the noting and the reporting of interesting cases.

The medical society is a great power in the profession for the quickening and development of intellectual life and for the breaking down of rivalries and prejudices among its members. The medical society cannot flourish unless a large number of the local practitioners are in the habit of careful note-taking (either on paper or on the tablets of the mind).

If the young practitioner is ever to be a teacher of medicine, he will find a double light thrown upon his themes by notes made long ago at the bed-side, in those years when he was not overburdened with remunerative practice.

The medical journal is especially dependent for its life and usefulness upon the labors of trained note-takers. Clearness of description, breadth of view, and rapidity of composition are as a rule not born in the doctor, but wrought into him by persistent effort to depict in writing what he has discerned by the senses. Any intelligent man can train himself to it, if he begins before he has become mouldy or gotten into ruts.

There is a field of note-taking which has been little worked, and which belongs exclusively to the family physician. We refer to the keeping of family medical records. Our knowledge of diathesis and the influence of heredity in the production of disease is still very incomplete and chaotic. The life history of a disease-force must ever remain incomplete unless the records of all of the diseases of each of the members of a family or clan are at hand for comparison and study.

The history of the rheumatic habit in children is a striking illustration of this truth. According to the views of Cheadle and others, some of its manifestations in children are quite different from those found in adults—chorea, tonsillitis, erythemas, crops of nodules and pleurisy being as clearly rheumatic processes as the joint and heart inflammations; and we find continually in our practice evidence of the truth of this theory, in patients who have received no intelligent or efficient treatment for the heart crippling rheumatic inflammations, because "RHEUMATISM" was not written large upon the joints of the extremities. If elaborate family records, reaching through generations, were kept by the family physician and his successors in office, the relations of such scattered symptoms to one another and their dependence upon great underlying currents of disease-force might be gradually learned, to the great benefit of the diagnostician and therapist, to say nothing of the patient.

#### THE CODE OF ETHICS.

It is in great form now-a-days in certain communities, with both physicians and laymen, to decry the code of ethics of the American Medical Association, which is the foundation for the codes of local medical societies. We believe that this is a mistake. We regard the code as an embodiment of the moral law as it bears upon our duty to ourself and to our neighbor; or, to express it otherwise, of the highest and most practical business principles. We believe that it would be endorsed by any great merchant of high principle.

The public has fallen into the error of believing that the code of ethics usurps the authority of the moral law in the estimation of the physician.

We regard it simply as an expression of the most enlightened medical thought and experience; an aid to a proper solution of the very difficult problems which beset the physician; a check which tends to restrain unprincipled and aggressive practitioners; and an authority which may be referred to in cases of dispute. It is helpful to a physician to be able to consult the printed opinions of the best medical men in such cases.

Some of the precepts of the code of ethics, such as its teachings in regard to the assumption of duties for a brother practitioner and the concealment of useful discoveries, come to us with a binding force, because founded upon the law of brotherly love and the law forbidding covetousness. Other precepts, such as those concerning consultations with irregular practitioners, and undercutting of fees for the sake of competition, are simply bits of human experience—showing what is believed to be for the best interests of medical science and of the public in the long run.

It is a great comfort to belong to a profession which has, down the ages, frowned upon everything degrading or unworthy of the highest manhood and the best service to mankind, whether within or without its fold.

## A PLEA FOR CONTRIBUTIONS.

In the coming of the spring and early summer, when the turtle-dove is cooing to his mate and the gudgeon is basking on the river shoals, while the numerous and talkative English sparrow is making things lively in the cities, we hope that our readers will not forget the editor and his desire to make the "Original Article" columns of the JOURNAL attractive. Let those who wish to dig deep into the archives of medicine or to go into scientific researches send their papers along; but let not the man of retiring disposition and moderate literary gifts hesitate to jot down some of those personal experiences and observations of the past winter at the bedside, which make his company so agreeable to his medical friends. Don't be afraid of a misspelt word or a grammatical error; such things it is the business of the proof-reader or the editor (with dictionaries at their elbows) to correct. While we cannot agree with the Johns Hopkins professor who was sorry he had wasted so many years learning to spell, we feel that such matters are secondary and that accurate observation and bedside facts are of the most importance.

Any observation in regard to the application of a drug or other therapeutic agent in a difficult case is worthy of record. The drugs known and valued in one community are practically unknown in a neighboring district.

Then, we want the reports and papers of county societies in Maryland and adjacent States.

Sharpen up the old goose-quill, brother, and surprise us with a communication for publication.

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### Hospital Reports.

#### ANNUAL REPORT OF THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL FOR 1891.

JULIAN J. CHISOLM, M. D., SURGEON IN CHIEF.

The hospital work for the year presents sufficient items of interest to warrant comment. The number of cases treated was 10,003, of which 7,364 were eye patients, 1,458 suffered with ear affections and 1,181 were throat patients. There were 1,127 cases among negroes, which represent fairly the proportion of the colored to the white population of Baltimore City.

Of the eye cases the first tabulated were lid affections, always numerous, this year numbering 1,280. There were 18 cases of "lid cancer" and 181 of "tarsal tumors," a larger percentage than in preceding years. One item of special interest was 13 cases of pediculi of the lashes. In the preceding 13 years of hospital work only 12 cases in all had been recorded. The marked influx of this curious malady is explained by the admission of Russian and Polish Jews to the Dispensary. They were recent arrivals in this country and had not been here long enough to have their home habits disturbed. The louse from the head, as is well known, is never seen on the eye lashes, nor does the body louse locate itself in these hairs. It is the crab louse of the pubis that is found attached to these cilia. One of these cases of phthiriasis was in a negro child, and a second in a

well-dressed white native, a 12 year old boy of apparently cleanly habits. The insects were destroyed by rubbing the edges of the lids with yellow oxide of mercury ointment.

Among the affections of eye muscles there were 264 cases of strabismus. This hospital has done good work in removing these ugly deformities from the streets of Baltimore City. At one time pedestrians would constantly encounter cross-eyed people. Now they are not often met with. 1,369 cases of squint have been operated upon in this institution.

In the list of conjunctival affections there were 48 cases of "purulent ophthalmia" of the newly born. When infants are brought to the hospital early enough, with the cornea still clear, no eye has ever been lost from this destructive disease. Unfortunately we see too many with cornea already perforated under the treatment at home, whatever that may have been. The hospital course, so uniformly successful, is the daily instillation of a drop of 1 per cent. solution of nitrate of silver; and the persistent use at home of a borax solution (grs. x to  $\xi$  i), the eyes being kept clean by the hourly use of these drops. The nitrate of silver solution is used as long as the pus secretion continues, viz., once a day at the hospital. This necessitates a daily visit for inspection for from 10 to 20 days. The earlier the nitrate of silver is used, the more prompt the control of the suppuration. A stronger drop than 5 grains of the caustic salt to the ounce of distilled water is never used, and the one drop never applied oftener than once in the 24 hours.

There were 16 cases of "vernal conjunctivitis." This very tedious disease yielded promptly to free cauterization of the thickened conjunctival rim around the corneal border by means of the galvano-cautery. The same remedy was found efficacious in cases of episcleritis. In some cases the red thick lumps under the conjunctiva, which had resisted all other remedies, disappeared promptly under the cauterization.

Of cataract cases, 570 sought treatment at the hospital during the year 1891. 188 of these were operated upon. There were 134 extractions, 88 without iridectomy and 44 with iridectomy. Under the aseptic precautions of plunging all instruments in boiling water both before and after using, there has not been a single case of corneal sloughing after cataract operation this year. This operation has now become the ideal one in surgery, and in the hands of skilful surgeons good results are nearly always obtained. In all cases of simple senile cataract I omit the section of the iris in the extraction. Six cases of senile cataract were ripened by needling. They were sufficiently advanced to interfere with useful vision, and yet with no promise of maturing for many months. They were in old persons who had not the time to wait the slow processes of nature. In from one to two weeks after the capsule was opened all transparent lens substance had become opaque. The lens was then extracted without iridectomy and with excellent results. In one of these cases a persistent diarrhoea necessitated frequent daily visits of the patients to the water-closet from the day after the operation, yet  $V \frac{2}{3}$  was obtained. The tendency is to perform cataract extractions without awaiting the complete maturing of the lens. In extracting senile cataracts I remove the anterior capsule with forceps. It is an improvement over the cystitome, as to a great extent it does away with the secondary operation for capsular films at a subsequent period, and gives more immediate good vision.

Operations on the eye-ball show 50 enucleations, three eviscerations, and 8 optico-ciliary neurectomies. I find much benefit from this last operative procedure in preservation of comparatively good looking eyes made painless by nerve section. In this hospital 72 neurectomies have been performed. In only three cases as far

as known was it necessary to enucleate because of returning pain in the eye-ball. I have had no trouble in the operation and no bad consequences from it. The eviscerations were in cases of pan-ophthalmitis with much swelling of eye-ball and eye-lids. Recovery by evisceration is not so prompt as after enucleation. To many surgeons it seems a safer practice to leave the socket tissues undisturbed when the eye-ball is full of pus, and yet in my own experience I have never seen trouble from enucleating eyes during the height of suppuration.

Although chloroform is the general anæsthetic administered at this hospital for all tedious, painful operations, the *bromide of ethyl* has been in constant use since 1881, for all painful operations of short duration. A drachm of this liquid in an air tight cone held over the nose and mouth of a patient will ensure complete anæsthesia in less than one minute, and no one can resist its narcotic influence. It has been administered at the hospital thousands of times in the past ten years and always with satisfaction. It is a powerful remedy to be used with caution. With the watchful care that is practised in its administration it has been found always efficient and always safe. My assistants have become familiar with the mode of administration. We use a thick towel folded in cone form, with paper between one of the layers of towel to keep the air out and shut in the anæsthetic. The hollow of the cone makes a sufficiently commodious air chamber. The base of the cone, a soft towel, can adapt itself as an air-tight joint upon the face. It is necessary to make the atmosphere breathed a saturated etherized air, then anæsthesia comes after a very few inhalations. If the air be admitted freely from without no narcotism takes place.

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### Medical Progress.

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#### ANILINE INJECTIONS FOR HOPELESS CANCER.

(Translated and condensed for *Lancet* from *Wiener Klinik*, January, 1892.)

Prof. Mosetig-Moorhof thinks it desirable, in consequence of the numerous inquiries made of him and the appeals for the publication of cases, to put on record the results that he has obtained up to the present time in the treatment of malignant growths too advanced for operative relief by the injection of the aniline dyes. In 1883 he injected a 1 per cent. watery solution of aniline trichlorate (free of all traces of arsenic) into a man fifty years of age, who was the subject of a sarcoma of the inguinal region as large as an orange. The injection was repeated every two or three days well into the tumor. In two month's time the mass had decreased to a nodule the size of a nut; it had in part broken down and in part shrivelled up. The man remained well for a year, and then died of an acute pneumonia without any relapse having taken place. Notwithstanding this very successful case the treatment had to be abandoned for a time owing partly to the unpleasant constitutional effects that were produced and partly to want of material. In 1890 Professor Stilling's pyoktanin (Merck's preparation) was tried, and owing to the fact that it combines a certain amount of antiseptic power with a high degree of innocuousness it has been largely used since. The technique of the treatment is then given at some length. A special syringe, holding from two to three grammes, is used with long and wide cannulæ. A Pravaz syringe does not hold sufficient, and with a small needle greater pressure has to be exerted on the piston. Some special curved cannulæ are used for injections into the tongue. The needle must be most carefully rendered aseptic, and

the syringe should not be used for any other purpose. An aqueous solution should be used, and should be carefully filtered (if possible, through an aseptic asbestos filter), as it has always a tendency to precipitate, and so block the cannula. To avoid this, also, it is advisable not to use a more concentrated solution than 1 in 500. Disinfect the skin. The cannula should be plunged into healthy skin immediately beyond the tumor, and pushed in deeply towards the edge of the growth. When it has penetrated the latter, the solution should be slowly injected. As much as from two to twelve grammes of the 1 in 500 solution may be injected at each sitting, the injections being made either at one spot or several, as may seem necessary. Where the surface of the growth is ulcerated, the needle must be introduced further away and pushed deeper, as there is always an escape of the fluid from the surface of the ulcer. In tongue cancer it is important not to inject through the floor of the ulcer. Such a proceeding may be followed by cellulitis from the introduction of septic matter from the floor of the ulcer along the track of the needle. In cases of enlarged submental glands or epithelioma of the floor of the mouth the injections should be made from the outside.

The objections brought forward against the treatment are then dealt with. Prof. Mosetig-Moorhof affirms that in his experience, and after many hundreds of injections, there is no danger of any coagulation occurring if the drug is injected by accident directly into the blood stream. This clinical experience is supported by Ehrlich's experiments, where it was found that the methylene blue when injected into the blood-vessels of dogs caused no coagulation and no ill effects. This point was further exemplified in a case of very large pulsating soft sarcoma of bone in a child where a profuse rush of blood occurred through the cannula, and where pressure had to be applied after the injection had been made in order to check the bleeding. Here the drug must have got into the blood stream. Nevertheless the pain disappeared and the boy felt better.

It has been found that the harder varieties of sarcoma and the carcinomata, especially the former, are likely to derive more benefit from this injection treatment than are the the softer, more vascular, and rapidly growing sarcomata. The tumors of the soft parts are likewise more amenable to the treatment than are those of bone. Inflammation never occurs, unless septic material has been introduced with the cannula. Hence the precautions to render the instruments aseptic, and to avoid injecting through ulcerated surfaces. Some œdema may occur soon after injection, and persist for some days. This is probably due to the pressure of the fluid and its slow absorption from the site of injection.

Pain is rarely felt for more than a few minutes. It is due to the distension of the parts by the large amount of fluid injected. In some cases it may last an hour or two. In only two cases, where twelve grammes had been injected at one spot, there were some shiverings and a slight rise of temperature.

The benefits are thus enumerated:—1. Relief of pain, usually very marked and often very rapid. This is explained by Ehrlich's observation that in the living subject these dyes are found first of all to affect the nerve endings. This relief of pain after a few injections may be permanent. There is, however, no relief of the distressing pain in cases of "carcinome en cuirasse." 2. Improvements of general health. The relief of pain leads to natural sleep, improved appetite, and gain in weight. 3. Mental improvement. It cheers and lightens a patient's end by exciting hopes and rousing him from hopeless despondency. 4. Improvement in function of various organs—e. g., the tongue may become movable in epithelioma linguæ, etc. 5. Shrinking of the tumor. Even in the softest and most rapidly growing tumors some retardation of the growth may be produced and per-

haps some diminution in bulk. In suitable cases this may be very marked, and may occur either from breaking down of the growth or shrinking up of it. The two processes are usually combined. Secondly affected glands may shrink as a result of injections into the primary growth. 6. Cicatrisation of a malignant ulcer may occur, especially when the drug is directly applied to the surface. 7. A foul ulcerated surface will clean and fœtor will diminish. It is therefore found in actual practice that shrinking of the growth, and even actual cicatrisation, may be obtained. Sufficient time has not yet elapsed to enable any opinion to be formed as to relapses. Only two out of more than seventy cases treated by Prof. Mosetig-Moorhof have up to the present time (one year from the beginning of the treatment) relapsed. The treatment should only, of course, be used in cases that are beyond the reach of operation. It cannot do harm, and may do much good. As an example of the good results to be obtained, there is appended a table of ten cases out of seventy or more treated by Prof. Mosetig-Moorhof.

I. Myeloid of lower jaw in woman of 66 years. Tumor disappeared. No return in eight months.

II. Subperitoneal pelvic sarcoma in man of 65 years. Reduced to one-third its size. Stationary the last eight months.

III. Supra-mammary sarcoma in woman of 32 years. Reduced to one-half its size.

IV. Sarcoma of neck in man of 45 years. Reduced to one-fifth its size. Pain all gone. Ulcer cicatrising.

V. Epithelioma of cheek and eye-lid in woman of 65 years. Almost entirely cicatrised. Small spot left.

VI. Epithelioma of nose and eye-lid in woman of 47 years. Disappearance and complete cicatrisation of ulcer; local recurrence.

VII. Carcinoma fibrosum of breast and axillary glands in woman of 68 years. Reduced one-half. Glands still swollen. Cicatrised except small spot.

VIII. Epithelioma of tongue and glands in man of 45 years. Partial cicatrisation. Glands stationary. Tongue movable.

IX. Epithelioma of palate and cheek in man of 60 years. Reduced to one-third its size. General health improved.

X. Carcinoma vaginae recurrent after amputation of uterus. Shrinking and cicatrisation of ulcerated parts. Death from pelvic cancer.

#### PHENOCOLL HYDROCHLORATE.

We glean the following from a communication by Dr. Isaac Ott, in the *Jour. Nervous and Mental Diseases*, Feb., 1892 :

This body is a white crystalline powder, soluble in sixteen parts of water at 62° F. It is the hydrochlorate salt of amido-acet-para-phenetid. This new combination is a phenacetin rendered soluble by the addition of an amido group. Alkalies and alkaline carbonates throw down from the hydrochlorate solution the pure base, phenocoll. The pure base is soluble in hot water, but dissolves to only a small extent in cold water.

In experiments on rabbits, Dr. Ott learned that : The action of phenocoll upon the circulation is one of depression. The pulse and arterial pressure fall after a dose by the jugular. The reduction of the pulse is not due to an excitation of the pneumogastric, but the cause must reside in the heart itself. It is reasonable to infer that weakness of the heart itself is one of the principal factors in the depression of arterial tension. Phenocoll first increases the respiratory movements and then reduces them. Previous division of the vagi does not change the state of affairs. It temporarily reduces the temperature of the body.

Phenocoll is a drug which may be recommended in the pains of influenza, rheumatism and gout. In the neuralgias of the intercostal or other peripheral nerves it will be found valuable. As an antipyretic its action is not of long endurance. Unlike phenacetin, it is soluble in water and it is probably quite as effective for the subjugation of pain. For the reduction of fever phenacetin is superior.

#### TREATMENT OF CHOREA BY EXALGINE.

The author has lately read a paper before the Faculty of Medicine of Berlin giving details of 35 cases of chorea treated by exalgine. The results were very encouraging. The dose employed was three grains repeated three to five times a day; the duration of the treatment varied, according to the gravity of the case, from eight days to four months. The results were obtained the most rapidly where the treatment was begun at the onset of the disorder. In some of the cases considerable amelioration was established after 12 doses (36 grains) of exalgine had been given, but in the majority double this number of doses was necessary before improvement was manifested. One child, of eight years, was completely cured after 12 doses of 3 grains each. The total maximum quantity of the drug employed was in a severe case in which about 1700 grains were given in the course of more than three months.

In cases where the choretic movements were very violent the condition of the patient was aggravated, in spite of the exalgine, for the two first weeks of treatment, to be ameliorated afterwards, slowly but progressively, until they were arrested.

In addition to its action on the muscular movements, the medicament influenced also very favorably certain other nervous phenomena, such as the mental excitement, feebleness of memory, salivation, articular pain and formications in the fingers and arms. These symptoms improved very rapidly during the first week of treatment.

The drug was frequently well supported, but frequently, after prolonged use, ringing in the ears, nausea, cephalalgia, and vertigo were complained of. In four cases there appeared a generalized icterus.

None of these phenomena were ever of a serious nature and they required no treatment other than the temporary suspension of the drug. After their disappearance the exalgine was again given without the reappearance of the unpleasant symptoms.

In conclusion, M. Lowenthal expresses the opinion that exalgine should be placed among the antichoretic remedies.—Dr. H. Lowenthal, in *La Semaine Médicale*, February 13, 1892.

#### AFTER-TREATMENT IN SURGERY.

In an article by Dr. Roberts (*American Journal Medical Sciences*, March, 1892) he says :

Many cases need little or no medical treatment subsequent to operation. The wound, if it continues free from suppurative or septic infection and is not irritated by too tight sutures, is practically painless. The immediate smarting of the wound, often very slight and at times altogether absent, is to a great degree avoided by the preliminary hypodermatic injection of morphia and atropine before anæsthesia. Acute pain after operation usually means that the sutures are too tight, the dressings badly applied or that the wound is not free from bacterial infection.

Because of the discomfort occasioned by the surroundings and the restraint of the dressings, and because of the nerve strain of the day, I, as a rule, give bro-



mide of potassium and chloral toward bedtime of the day of operation, and perhaps also the next night. I usually give forty grains of potassium bromide and fifteen or twenty grains of chloral. Sometimes it is necessary to repeat this dose once or twice during the night, at intervals of about an hour. This anodyne I administer more for the purpose of allaying the nervous excitement than because there is actual pain. It has not the objection of morphine, which diminishes the secretions, constipates the bowels, and impairs the appetite.

Ordinary cases need no other medicinal treatment, except an occasional laxative to keep the bowels open. I agree with Dr. Agnew, a former president of this Academy, who says: "So long, however, as a patient is doing well, drugs are an impertinence."

If there has been much bleeding, I give iron and quinine as a tonic, and occasionally I use these drugs as a placebo when there has been no special hæmorrhage. Opiates are always to be avoided in the after-treatment, if possible. The stress recently laid upon this point by abdominal operators is simply an axiom of good general surgery which I have long followed. The use of frequent doses of opiates indicates in most medical and surgical conditions an unwise physician or surgeon. Their administration masks symptoms, interferes with secretion, and is liable to establish the opium habit. If I am obliged to use morphine or opium, I do not give it hypodermically, as this method is the most seductive. The name of the drug used is not mentioned in the patient's hearing.

The antipyretics now so fashionable I practically never use. The elevation of temperature, which occurs in aseptic cases within about thirty-six hours after operation, which is supposed to be due to absorption of fibrin ferment, needs no treatment; nor does fever resulting from nervous excitement. A rise of temperature presumably due to septic changes in the wound is to be treated by renewal of the dressings, irrigation of the wound, cutting of sutures, or cleansing of drainage-tube rather than by medicines which act simply by depressing the temperature. They afford the surgeon a false sense of security and may mask the true condition of the wound. Like opiates, they conceal truth, perturb the normal functions, and simply combat a symptom which is meant by nature to call the surgeon's attention to the fact that his work needs revision.

#### A DIFFICULT FACE PRESENTATION.

In the *University Med. Magazine*, March, 1892, Dr. Hamilton relates a case of difficult face presentation, in which the patient, aged 39, was taken in labor with her second child on Sunday morning, March 27, 1887. On examination, a face presentation was discovered, with chin regarding left acetabulum. As the patient possessed a roomy pelvis, and had had a comparatively easy labor in her previous confinement, he decided to wait. The pains were strong and expulsive; but, to his surprise, the head refused to revolve, and the occiput remained lodged, the occipito mental diameter having become exactly in line with the transverse diameter of the pelvis. Being now convinced that the head was locked, and nature unable to overcome the difficulty, he applied the forceps, but was unable to move the head in the slightest degree. He now requested the husband to secure the services of an assistant, and after a couple of hours Dr. Samuel Lane arrived, and, after careful examination, recommended another attempt with the forceps. This was as fruitless of results as the former attempt, and they concluded that the child must be sacrificed, or mother and child would both perish.

Then, and not until then, the patient was etherized, and he proceeded to open the child's head by making an orifice through the frontal bone, anterior to the

coronal suture, the highest point accessible, because of the forcing back of the forehead by the expulsive pains, in the vain effort to cause the chin to advance.

With some trouble the brain was broken up and removed with a long-handled spoon, a sharp hook was fixed at the base of the occiput, and, with his finger inside the cranial vault as a guard, he brought the head downward and forced the chin backward. An application of the forceps was now easy, and he soon succeeded in delivering the child, a large male.

To his surprise and very great satisfaction he discovered the shoulders cross-wise (when drawing the head downward with the hook), and the sternum regarding the promontory of the sacrum. This position had placed the occiput directly in contact with the right shoulder of the child, and absolutely prevented its retrogression, and, as a result, the chin could not advance.

The mother made a good recovery; she has had three abortions since, and is now in the ninth month of a successful pregnancy. He is exceedingly curious to know whether another anomaly of the kind will present at her coming labor.

### Medical Items.

"Have your teeth pulled out for a Christmas present," was the cheerful sign displayed by a London dentist for a few weeks before the holidays.

It is announced by the press that Dr. J. L. Bauer was expelled from the Faculty of the College of Physicians and Surgeons of St. Louis for introducing to the class as his "colleague," Dr. Etavard, who has made himself obnoxious by his methods of advertising.

The Medical Examining Board of Virginia will meet in the city of Richmond, Va., Capitol Building, Tuesday, April 19th, 1892, at 8 o'clock P. M. This evening's session will be for the routine business of the Board, such as arranging questions for examinations, etc.

The examination of applicants for license will be begun promptly at 9 o'clock on Wednesday, April 20th, and will continue two days. Every hour of time from 9 A. M. to 11 P. M. of each day is occupied in the examinations (except the hours from 3 to 4 P. M., for dinner, and 7 to 8 P. M., for supper.)

Applicants for examination must be on hand from the beginning of the first examination, which will begin at 9 A. M., Wednesday. The first examination will be on chemistry; the questions will be put on the blackboard at 9 A. M., and are taken down at 12 (mid-day), when the subject for the next examination will be immediately put up and taken down at 3 P. M., etc. Questions once taken down are not put up again. Hence the great importance of each candidate being punctual at 9 A. M., Wednesday, April 20th, 1892.

Any party wishing to be examined should come prepared with the examination fee of *five dollars* required by law, and report immediately to the Secretary of the Board, Dr. Paulus A. Irving, of Farmville, Va., who will be in the hall *half an hour* before the appointed time, to issue in due form the permits for examination. Dr. Hugh M. Taylor, of Richmond, *President*, Dr. Paulus A. Irving, of Farmville, Va., *Secretary*.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.

Any one sending the following number of the JOURNAL in good condition will be paid ten cents for same: Vol. XXIV, No. 5, Nov. 29, 1890.

# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

- Studies in Plaster Jackets and How to Make  
Removable Plaster-of Paris Corsets. By C. C.  
Barnwell, of Baltimore. . . . . 441
- Infant Foods other than Breast Milk. By A. K.  
Bond, M. D., Baltimore. . . . . 450

### EDITORIAL.

- The Plaster Jacket. . . . . 453
- Gymnastics for College Girls. . . . . 454

### CORRESPONDENCE.

- Who Makes Opium Slaves? . . . . . 455

### MEDICAL PROGRESS.

- Death from Impaction of Feces.—Hæmatemesis  
of Early Adult Life in Females.—Gonorrhœa  
and Child-Bearing.—Ancient Hindu Vaccina-  
tion.—Complete Subcutaneous Emphysema.—  
The Ordinary Water-Bed as a Means of Affect-  
ing the Temperature of the Body.—Pleurisy.  
—Orbital Hæmorrhage in Children.—Artificial  
Respiration in Cyanosis from Plugging of the  
Bronchial Tubes. . . . . 456

- MEDICAL ITEMS. . . . . 461

## Original Articles.

### STUDIES IN PLASTER JACKETS AND HOW TO MAKE REMOVABLE PLASTER-OF-PARIS CORSETS.

AFTER THE METHOD OF THE LATE PROFESSOR LOUIS A. SAYRE, M. D.,  
OF NEW YORK. ADAPTED FOR HOME WORK  
BY C. C. BARNWELL, OF BALTIMORE.

Plaster-of-Paris is a substance well fitted by its composition and qualities for use in making bandages. It is perfectly pure, and being composed of calcium is similar to bone. It is permeable by moisture, therefore does not interfere with the transpiration through the skin. The *greatest advantage* is, that while in the plastic state it can be moulded to fit any inequality of surface, or deformity of the body. It "sets" or hardens very rapidly and retains the desired form in an unbreakable jacket.

It is my purpose in this article to explain, in a simple and practical way, how to make plaster bandages, especially those which are used for jackets to relieve or prevent spinal deformities.

The "potter's plaster-of-Paris" is the best for this purpose, and should be of the very finest quality. That it is used by dentists gives it the name also of "dental plaster." A coarser quality will not work smoothly, will not give a pure white surface, and will not make as light a jacket. From one to three pounds

will suffice for one jacket. A barrel of potter's plaster costs about three dollars. If the barrel is kept in a dry room and used with the "quick-setting compound" (shortly to be described), the plaster will not fail to make good bandages, although kept as long as three months.

#### TO MAKE THE BANDAGES.

Procure a piece of white cross-barred leno ("harmony lining" is the trade name), tear it into nine strips lengthwise, 12 yards long by  $3\frac{1}{2}$  inches wide; *clip the edges two or three threads deep, a half yard apart, to prevent long ravels*. Measure the long strips into three equal parts, and notch V the edge one inch deep to show where to cut it afterward. In this way every roll of bandage must measure four yards in length.

#### THE DUSTING BOX.

A suitable box to prepare these bandages should be made ready as follows: A cigar or chalk box, 5x5 or 5x8 inches, will answer nicely. Cut a horizontal slit in each end just above the bottom board for the leno strip. Pass the leno strip through the slit at one end, draw it across the box close to the bottom board, and pass it out at the other end of the box. The slit must be just wide and high enough to fit the strips of leno, otherwise too much plaster will come out. After the end of leno strip is passed through, fill the box with plaster, and draw the strip slowly through the box placed on a table. It will catch enough plaster, as it comes through, to make a thin, smooth layer, and it is then to be rolled up *loosely*, so as to leave an opening through the centre of the roll. When the notch V is reached, cut off the bandage roll, and set it on end in a tightly closed box, or tin bucket.

This variety of leno is very heavily "sized" with starch, therefore bandages made with it are really starch and plaster bandages combined; possessing the advantages of both, they require less plaster to make a strong, light jacket, and also avoid the use of tin strips formerly used to strengthen the jackets.

#### THE "DRY" BANDAGES.

Are made as follows: Take of white muslin, "fruit of the loom," six yards, tear it lengthwise into nine strips, clip both edges three threads deep, every half yard, to prevent long ravels. Roll up these strips *tightly*, and set aside. They are used dry to protect the under-vest from the wet plaster bandage, and to retain the padding in place.

#### THE TOOLS AND FITTINGS.

Those whose practice justifies it find it convenient and economical to provide themselves with the tools necessary for making the straps, for lacing jackets in front. These tools may be bought from dealers in shoe findings. One button-hook setter, \$1.75; one spring punch No. 6, 40 cents; one Webster knife, 8 cents; one patent awl haft, 6 awls, 25 cents; one pair of dividers with screw, 18 cents; one pair of nippers; one whetstone, 75 cents; one ball red saddler's flax, 25 cents; one paper O O needles, 5 cents; one strip sheet zinc, 2x20 inches; two knives made to order; one side leather.

The leather should be light colored, of the quality of driving-reins, cut  $1\frac{1}{4}$  inches wide, in long strips. Afterwards straps of this can be cut into lengths to suit the front edge of jackets.

The lacing hooks are similar to those on gentlemen's shoes. Gilt hooks can be obtained from shoe makers, or from wholesale dealers, at 90 cents a thousand. These hooks are to be set two inches apart, near one edge of the leather straps.

Small holes made with an awl nearer the edge than the hooks will facilitate

sewing the leather straps to the piece of unbleached muslin, 4 inches wide, made one inch longer at each end than the leather straps. These pieces of muslin are pasted on before the jacket is set in the oven to dry.

The two knives are made to order, as follows: The blade,  $4 \times 1\frac{1}{2}$  inches in width, is set in a wooden handle, flat or square. The front edge of the blade should be straight, the back is ground to form a curve toward the point of the front edge. On this curve are filed saw-teeth, for about the space of  $1\frac{1}{2}$  inches from the point. One of these knives should be used exclusively for cutting open the jackets, as that requires a keen, sharp blade. The second knife should be used for cutting and smoothing the jacket after it is removed from the patient's body.

Other needful articles are powdered alum, coarse salt, white sheet-wadding, corset lacets, needles, thread, pins, scissors.

#### RECLINING CHAIR.

An invalid's rolling extension chair is most convenient for the operator and patient. When the jacket is made and the patient leaves the hand-swing, the chair is rolled near, and the patient takes a seat on the cushions, and lays the head backward. Then, while the patient remains passive, the operator works the extension screw, so as to place the patient's body as nearly horizontal as is comfortable. The patient must make no effort to lie down, as such effort is apt to crease or break the newly-made jacket. A child may be laid down on the chair, already extended.

#### THE QUICK-SETTING COMPOUND.

It is made of powdered alum, 2 teaspoonfuls; of coarse salt,  $\frac{1}{4}$  teaspoonful; of warm water, 1 gallon.

#### THE PASTE

used in finishing the jackets is made thus: Boiling water,  $\frac{1}{2}$  pint; powdered alum,  $\frac{1}{2}$  teaspoonful; best wheat flour, 1 tablespoonful. Moisten the flour with warm water, stir it into the water and alum while boiling, and cook until clear.

#### THE ZINC STRIP.

This should be cut,  $2 \times 20$  inches, pointed at one end, and covered with one or two layers of white muslin. A bit of cotton wadding may be placed over the pointed end to prevent it from hurting the patient when it is used in removing the jacket.

#### THE OVEN OR DRYING BOX.

This is used on gas or coal-oil stoves. Large sizes may be made of sheet-iron at the tinnerns. Outside measure,  $20 \times 24$  inches square. Door,  $16 \times 18$  inches.

When the jacket has been placed inside, the oven should be set over the stove, with moderate heat. Two or three hours will suffice to dry a jacket thoroughly.

Before going further I may quote some extracts from Dr. Sayre's great work, "Spinal Disease and Spinal Curvature; Their Treatment by Suspension and the Use of Plaster-of-Paris Bandages," which will prove valuable to the operator and the patient.

On page 12, Dr. Sayre says: "The jacket is to be worn as long as it is easy, from one to two or three months, or until the *patient* has grown to such an extent as to make it necessary to remove it, and apply another."

Page 13: "In addition to the *perfect comfort* of the jacket, and the absolute immobility which can be obtained through it, it has this further advantage, that it may *easily be applied* in any part of the country, without the trouble and expense of resorting to any instrument maker."

Page 18: "The patient is to be *gently* and *slowly* drawn up by means of the apparatus until he feels *perfectly comfortable*, and *never beyond that point*."

On pages 21 and 22, Dr. Sayre says: "I wish to give, or rather repeat, a word of caution, fearing that I may not have enforced it with sufficient distinctness already. It is this: do not attempt the impossible—do not try to straighten curved spines, the result of caries, that have become partially or completely consolidated. If nature has already thrown out ossific matter, and adhesions are beginning to take place, do not break them up by too severe extension, but simply extend the patient very slowly, so that the contracted muscles alone will yield, *until the patient says he feels comfortable, and never beyond that point*."

Again he says: "I would advise the careful study of each case and the modifications of treatment applicable to each individual."

Lastly, he remarks on page 121: "When last seen, in November, 1876, he was greatly improved, and simply used his jacket as a corset, lacing it up in front."

#### SUSPENSORY APPARATUS OR HAND-SWING.

A complete apparatus can be obtained from the chief instrument makers in large cities, notably John Reynders & Co., 303 Fourth Ave., New York City; price \$6 to \$16.

The axillary straps and chin collar are not necessary, as self-suspension is more agreeable, and gives better results. This is done by letting the patient hold tightly to the cross-bar, while the operator slowly draws him up until he says "stop." The rope is then fastened to a line cleat. For comfort in holding on to the cross-bar during the application of the jacket, the bar should have a piece of soft woolen cloth sewed over it.

This apparatus is a cast-iron cross-bar 17 inches long,  $\frac{1}{2}$  inch thick, slightly bent into the form of a yoke. In the center of the bar is a swivel-hook by which it is attached to the pulleys, which are double cast-iron pulleys, connected by 12 yards of cotton rope. The upper pulley should be attached to a strong screw-hook in the ceiling, the lower pulley to the cross-bar. The cross-bar should have projections or knobs at the ends, and other knobs about 5 inches from the ends, to retain in place of axillary straps and chin collar, should it ever be necessary to use them.

#### THE UNDER-VEST.

Can be obtained from the instrument makers for \$2 or \$3. A close-fitting merino vest will answer very well. It may also be made of Jersey cloth, or eider-down flannel without sleeves, but with straps over the shoulders. Even plain unbleached muslin will do.

When used as a corset, the jacket may be worn outside the ordinary under-vest. A convenient skirt for protecting the lower limbs and underclothing is made of unbleached muslin,  $1\frac{1}{4}$  yards.

Whatever plaster adheres to the clothes, or hands, can readily be removed by salt and water.

#### PREPARATION OF THE PATIENT.

The patient is prepared for the application of a jacket by the removal of all clothing above the hips. An under-vest, such as that before described, is fitted closely to the body, and is then drawn down smoothly over the hips. A yard of unbleached muslin is then thrown around the lower limbs, over the underclothing, and fastened securely over the lower edge of the under-vest to keep it in place. White cotton sheet-wadding is used for padding, to protect prominent or

tender points, folding it 4 or 6 times, placing it under the vest, and pinning it in place. For instance, over the crest of the ilium (hip bone); spinous process, (lump on the back); stomach ("dinner-pad"); and in the case of women, over the breasts. The patient, if able to stand, should be placed beneath the hand-swing standing on the floor or on a chair, as is most convenient, so that the operator will not have to work stooping or kneeling. A child too feeble to stand may be rested in the mother's lap, or on a high stool. If he is not able to hold the cross-bar, the hands may be raised above the head by an attendant. Very young children may need a few whiffs of chloroform to quiet them sufficiently, while seated, to allow the bandages to be easily applied.

It is well to let a child become familiar with the hand-swing, by playing with it, before the application of the jacket. Extreme caution should be used that the child is not uneasy, unhappy or crying, during the application. It is useless to attempt to apply a jacket to a frightened, struggling child, as any sudden jerk or twist will cause wrinkles in the plaster, which will render the jacket unfit to be worn.

A bit of *mint candy* in the mouth during the application is very soothing to the nerves, and pleasing to the temper of the young and the old.

The patient, having been placed in position beneath the hand-swing, should take hold of it firmly, while the operator slowly draws the rope until he says "stop." The rope is then fastened to a line cleat or nail.

#### PUTTING ON THE BANDAGES.

The dry bandages are now first applied, by being rolled smoothly over the under-vest, each layer overlapping that above it by one-half the width of the bandage. Commence under the arms and cover the entire body. The whole surface of the under-vest must be covered by the dry bandage, to prevent the plaster bandage adhering to it anywhere.

While rolling on the dry bandage, one plaster bandage should be placed in the basin of warm water containing the alum and salt and be allowed to remain about two minutes. When this is taken from the water, another plaster bandage must be put to soak. That just taken out should be rubbed between the hands gently, until the plaster is of the consistence of thin cream. Commence applying this bandage at the waist line, and roll down spirally, lapping each over that before it two thirds the width, using some tension (stretching the bandage tight), and placing the layers smoothly.

After each bandage is put on, the surface should be rubbed hard, and firmly pressed together with the whole hand. This serves to weld the bandages, presses out the air, and makes the jacket compact, hard and thin.

When the body is covered down to the thigh or hip joint, begin at the waist line again and work upward spirally until the bandages cover the body, reaching high up under the arms. Dry plaster may be dusted on *very lightly* at a weak spot, or a section of bandage applied over it; *but the moist plaster in the basin should never be used again*; it is water-soaked and will injure the setting of the quick plaster. It prevents the bandages from setting hard and firm, and makes them spongy and weak. Too much dry plaster makes a heavy jacket, and when spread on the surface looks smooth at first, but, when hardened, easily flakes off and looks rough and ugly.

The time required to roll on the plaster bandages depends on the dexterity of the operator; but it may be done in from 5 to 30 minutes; the number of yards applied in that time being from 12 to 48.

Care should be taken to apply about the same thickness over the whole jacket. Five layers for a child, eight layers for an adult, will suffice.

The patient should be encouraged to remain standing in position, holding to the cross-bar, five or ten minutes after the plaster bandages have been applied; the operator or attendant supporting him, meanwhile, if necessary, under the arms, or moulding the jacket to his form.

#### TO SMOOTH THE JACKET.

The upper and lower edges of the jacket should be finished off by cutting the thin edge, under the arms and over the hips, with a knife, an inch deep on the lower edge and a half an inch on the upper edge. Fold the material over, outward, and smooth it down firmly on the jacket surface. This gives a neat finish and strengthens the edges.

Never use the wet plaster in the basin for smoothing the jacket, or for anything else. Keep the operator's hands always wet with the water in the basin.

After the application of the jacket a clean basinful of warm water, with salt and alum in it, will quickly cleanse the hands and nails.

The patient should take a seat on the cushions covered with a sheet, and incline the head backward. The operator should then work the extension screw so as to place the patient in a comfortable reclining position, and cover him with a sheet or blanket, until the jacket is hard enough to remove. A bit of mint candy at this stage of operation is very refreshing and somewhat stimulating.

Ten or fifteen minutes will give time enough for the complete hardening of the jacket. The test of this is its resistance to pressure, and a hard, ringing sound, as if from a solid surface.

If the "quick-setting compound" of alum and salt has been omitted, the jacket will not harden for hours, nor be as pure a white.

#### REMOVAL OF JACKET.

Place a small piece of cotton wadding over the rounded end of the zinc strip, and pass it up, beneath the lower edge of the under-vest, in front next to the skin. Push it gently upward until it comes under the chin. In a child with a prominent breast bone, the zinc strip should be pressed up as far as possible without causing pain, and the fingers of the left hand of the operator should then be slipped down beneath the upper edge of the jacket to meet it. With the sharp knife the jacket must be cut through in the middle line, straight from the chin down to the lower edge, care being taken that the knife cuts only down to the zinc strip, through and through the dry bandages, but *not* through the under-vest.

The zinc strips should now be removed, and the front edges of the jacket firmly held, and slowly opened and shut together several times. The patient is then assisted to stand up and hold the cross-bar, when the jacket may be easily taken off from the body. In the case of little children the jacket may be opened wide while they are lying on the pillows, and the *child may be lifted out of the jacket*. He should be quickly dried and dressed in warm clothing. A cup of tea and some crackers will refresh the patient before a depression of nerves can take place.

#### JACKETS NOT REMOVABLE.

Are made by exactly the same process, until the patient is laid down for complete hardening of the jacket. He must remain for 45 minutes quite still, as the moist jacket may yield to the weight of the body before it has set very hard. It would be well to let him sit before the fire, carefully wrapped up, to hasten the



hardening process. He should remain indoors a day or two, to prevent taking cold from the damp jacket.

#### FINISHING THE JACKET.

It should be cleared of all dry bandages inside, and the rough edges should be cut or rubbed smooth. If it is held up in a strong light, or if a candle is placed inside, the thin places will appear plainly. Short sections of plaster bandage may be wet and applied at these points. Wet the bandage in a fresh solution of alum, salt and water. On no account use the water in the first basin, nor the water-slaked plaster. Such wrinkles and rough places as appear can be made level by shaving down with the second knife; these will be found inside, about the hips, under the arms, and over the "lump on the back." After cutting them smooth, rub over the inside surface some freshly mixed plaster and water with alum and salt; this fresh mixture, of  $\frac{1}{4}$  teaspoonful of salt and alum to a pint of warm water, and  $\frac{1}{2}$  pint of plaster, may seem *too thin* at first; but it becomes thicker as it is worked in by hand, thus making a smooth, even surface on the inside of the jacket. If it is mixed too thick, it will flake off when dried.

The leather straps, with unbleached muslin attached, should now be pasted on the front edges of the jacket. Folding one border of muslin over, on the inside of jacket, like a binding, gives a neat finish to the front of jacket.

#### DRYING THE JACKET.

This is best performed by placing it in a tin oven, heated by a coal-oil or gas stove. To dry it thoroughly requires from one to three hours, in the oven; but it will become quite dry, if placed on a mantle-shelf above a cooking stove, or even in the sun for a day. When perfectly dry, it should appear pure white, and free from yellowish spots or streaks. Should it remain too long in the oven, or should the heat applied be too great, the leather straps will be injured, and the plaster substance will lose its tenacity and strength, and break up very soon.

#### PADDING AND FITTING.

When removed from the oven, the jacket should be "worked" slowly, by carefully opening and closing it, to render it so pliable that it may easily be put on or put off by the patient. Try it on and mark with a pencil where it must be cut away, under the arms, and along the lower edge in front; also mark wherever it is painful, so that this may be remedied either with the knife or with cotton wadding.

After it is cut away sufficiently for perfect comfort, some cotton pads should be *pasted* in the proper places. Make the pads from 4 to 6 inches wide and from 4 to 8 layers thick; paste a pad under each arm, and over each hip bone (crest of the ilium) inside the jacket, and turn the end of the pad over the edge of the jacket, thereby binding the cut edges of the jacket. Paste a thick pad over the bony projection of the spine inside of the jacket, and wherever it seems to be necessary for comfort; but remember that *too much* padding fills up the jacket, and will make it difficult to lace it close together in front.

#### LACING THE JACKET.

A corset lace should be tied at its middle to the lowest lacing-hook, and the jacket should be laced up the front with the two ends. Little children should be placed on their backs on the bed, since this position will render the lacing of the jacket easy to them and to the operator. When laced close together, the removable jacket is usually most comfortable, and as immovable as a closed jacket. It

is made removable like a corset, so that it may be taken off for bathing; to afford relief from unbearable pressure; to permit the dressing of abscesses; and in order that "the rubbing" which is so very comforting to spinal sufferers may be indulged in.

#### NO PAIN GIVEN.

The patient's feelings in regard to wearing the jacket constitute an absolute criterion, whether to leave it on, or take it off. *If it hurts, take it off* for a time, to see what is the trouble with the jacket (not what is the matter with the *patient*). This precaution should be observed especially in the first hour or two. The relief given by the support of the jacket is usually immediate; but if not so, the patient should on no account be allowed to suffer from the jacket, nor ever be forced to wear it against his will. Such suffering, being mental as well as physical, is torture, and if persisted in, will result in failure to improve the condition of the spine; and it has even resulted in the death of the patient.

Please bear in mind, then, that *the benefits of this method can be obtained without the least suffering*. If one jacket cannot be made comfortable at first, or becomes uncomfortable in *three or four days*, make a new jacket, and if necessary make a third in a week, or until you obtain one that gives perfect rest and comfort. Should a jacket become too large, though quite comfortable in all other respects, remove the muslin and leather strap from one front edge, cut away a strip one inch wide down the front and then paste the muslin on as before. Sometimes a patient seems to "grow out" of a jacket in a few days, and this repairing will make it as good as new. It is best to cut away, and shave out, any part of the jacket, as the patient desires, or suggests; especially if it is too high under the arms, or too long over the thighs.

Straps over the shoulders should not be worn.

#### REPAIRING JACKETS.

The reasons for doing so are: inability of the patient to have a new one applied as on account of illness, inclemency of the weather, or unwillingness of a child to undergo the application for a time.

If the jacket is broken and soft, and does not afford good support, treat it as follows: Put one gallon of warm water into a basin, with  $\frac{1}{4}$  teaspoonful of salt, and 2 teaspoonfuls of alum, and a quart of plaster-of-Paris. Immerse, or wet the whole jacket in this mixture until it is soaked through and through; hold it near the fire, or in the oven until it stiffens up to its former shape. Then apply sections of leno and plaster bandage, from 6 to 8 inches long, over the broken places, keeping the jacket in its original form as much as possible. These leno patches will not adhere to the jacket unless the whole surface has been saturated with thin plaster and water mixed with alum and salt, as before directed. A plaster bandage will set as hard as stone if left too long in water.

#### THE JURY MAST.

In cases of injury to the spine at the neck, or cervical vertebrae, when it becomes necessary to have the head supported, the jury mast, or head swing, should be used in connection with the plaster jacket.

This apparatus consists of three parts, and may be obtained complete from the instrument maker. The lower part, or base, is fixed in the jacket, an upper part extends over the head, and to it is suspended a chin collar. The base consists of steel or iron bars, forming a fork-shaped piece, with two prongs pointing downward and in the centre one flat prong pointing upward, with holes for screws. The second part consists of a curved steel rod, with a small cross-bar at its upper end over the head of patient. The lower end of this rod should be screwed to the upward prong of the base. The chin collar should be attached to the small cross-

bar and buckled around the chin and back of the head. The iron base has several narrow strips of tin attached to it, to follow the course of the ribs, and thereby fix the base securely in the centre line of the jacket. The plaster bandages should be applied, in the usual way, twice over the whole body. The iron base is then set in place over the spine, exactly in the middle line. Arrange the rib-like strips of tin on each side, and fasten them in place firmly with the plaster bandage, applying several layers over the whole jacket. It is best to separate the curved steel rod from the base before the latter is fixed into the jacket. When the jacket has set hard enough to remove, cut it off and finish it, as before directed.

When a new jacket is needed the mast base may be removed from the old jacket and used again. If the tin strips are broken off in the removal they might be replaced with strips of unbleached muslin sewed over the iron base. If the jacket over the base of the iron fork be first soaked with *strong salt and water*, to make it soft, it may be cut almost as easily as freshly applied bandages.

This holds true when a jacket has been worn closed for weeks and months. In such a case soak the surface to be cut with a strong solution of salt in warm water and cut through, keeping the surface wet as it is opened to the knife or saw.

Whatever plaster should adhere to clothing or sheets may easily be removed by soaking the articles, over night, in strong salt and water.

407 W. Hoffman St.

#### A POINT CONCERNING EPIDIDYMITIS.

In a brief article on the treatment of this disease in the *North American Practitioner*, Feb., 1892, Dr. Frank Lydston remarks :

I have nothing new or startling to offer in regard to the treatment of epididymitis, but desire to briefly direct attention to a practical point which I deem of great importance. The majority of practitioners are in the habit of dismissing their cases of epididymitis as cured as soon as the tenderness of the affected organ has sufficiently disappeared to permit locomotion. A moderate amount of induration of the epididymis is usually regarded as of trivial importance.

Anent this fallacious impression, it is a fortunate thing that man is endowed with two testicles, else sterility in the male would be much more frequent than appears to be the case. If the truth were known, however, it is probable that a much larger proportion of childless marriages than is generally supposed could legitimately be attributed to sterility of the male. We are undoubtedly too prone to lay the fault at the door of the womb or the still more abused ovary.

When we consider the delicacy of the structures of the epididymis, and especially the minute lumen of its tube, it is by no means surprising that the organ should go out of service as a consequence of blocking up from pressure of inflammatory exudate. Such indeed is very frequently the case. If by any chance the opposite testicle should one day undergo the same misfortune, the patient is apt to be as harmless from the procreative standpoint, as though he had been castrated. Patients of a gouty, tuberculous, strumous or syphilitic diathesis are peculiarly liable to permanent induration and blocking up of the epididymis. This is a very important point in the question of treatment, and is a very excellent reason why we should not consider our duty done in any case until the induration has been completely removed. Certainly there is more to be done than the relief of pain and difficulty of locomotion. The indications then in a case of epididymitis are not only to get the patient about, but to use such means as tend to produce absorption of the inflammatory exudate. These means may be required for a long period.

## INFANT FOODS OTHER THAN BREAST MILK.\*

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children in the Baltimore Medical College.

*(Concluded from page 428.)*

If you practise in one of our great cities you will most frequently recommend one of the foods prepared on a large scale by the great manufacturing houses. They are prepared according to certain definite principles and fall into several distinct groups. One group embraces the

## TORREFIED CEREAL FOODS.

The most important of these are Imperial Granum, Ridge's Food, Blair's Prepared Wheat Food, Hubbell's Prepared Wheat Food, and the Infant's Universal Food (of the Health Food Company). They are prepared by heating the grain, flour, or the "germs" of wheat, barley, etc., a long time (10 to 30 hours), at a temperature somewhere below the boiling point, in specially constructed ovens.

In this way the substance of the grain is converted into a powder or granular material, which is pleasant to the taste, very nourishing, and very digestible. Even alone when mixed with water it may be used as an infant food, but it is usually given to the infant mixed with diluted cow's milk, in which it prevents by its presence the formation of large, tough curds. This group of foods possess certain important advantages. They can be prepared so simply and cheaply that adulteration is not likely to occur; they are pleasant to the taste and very nourishing; they are to be made up with fresh milk, possessing the "anti-scorbutic" properties. The samples of *Imperial Granum*, *Ridge's Food* and *Blair's Prepared Wheat Food* which I present to you have been sent me through the courtesy of the manufacturers. You will observe them both in the original package, and as prepared with milk. Imperial Granum is made by Jno. Carle and Son's, New York; Ridge's Food, by Woolrich & Co., Palmer, Mass.; Blair's Food, by H. C. Blair's Son's, 8th and Walnut Sts., Philadelphia. I have recently had a baby thrive on Imperial Granum when foods of the other groups and sterilized milk disagreed with her. I have not yet tested the other members of the group, but have no doubt they are likewise worthy of reliance.

Another group includes the

## LIEBIG'S FOODS.

Mellin's Food, Horlick's (sold now under the name of "Malted Milk"), and Hawley's Food belong here. The material which they furnish for mixture with cow's milk consists of grain which has been partly converted into soluble substances by the fermentative action of malt. As required by Liebig's formula, they are prepared by keeping a mixture of milk, water, wheat flour, malt and bicarbonate of potash for a long time at a temperature favorable to the activity of the malt ferment. By such a complicated process the starch of the grain is converted into soluble dextrine and sugar. These soluble matters are strained off and evaporated to a dry powder.

By this method a digestible nourishing substance is obtained by which the casein of cow's milk may be made to coagulate in small flakes. *Horlick's "Malted Milk"* prepared by the Malted Milk Co., Racine, Wisconsin, which I now exhibit to you is a Liebig's Food which contains milk evaporated to dryness. You will note the taste and consistency when duly prepared with water for the infant's use. Mellin's Food, manufactured by Doliber, Goodale Co., Boston, Mass., is a Liebig's Food containing no milk. You will notice, in the sample handed you, its sweet taste, and its dry, granular consistence. In a private letter the agent informs me

\*Being a clinical lecture, delivered to the class February 20th, 1892, somewhat amplified.

that foods prepared according to Liebig's formula will not keep well. Therefore Mellin's food is prepared thus, leaving out the milk. He claims that it is far better for the mother to add fresh cow's milk, because the mysterious "anti-scorbutic" principles are not possessed by preserved milk or preserved milk foods.

The Liebig's foods suit many infants; but, as one might suppose, a food containing free bicarbonate of potash, malt, and large quantities of malt sugar must disagree in a certain number of cases.

A third group comprises the

#### CONDENSED MILK FOODS.

It is represented by Nestle's Food, Anglo-Swiss, American-Swiss, and Gerber's Foods. In the condensed milk foods, condensed milk is mixed with about an equal weight of flour (of wheat or oats), which has been thoroughly baked and ground to powder; and the mass is then evaporated to dryness. They thus combine to some extent the qualities of the Torrefied Cereal Foods with the qualities of Condensed Milk. They are open to the same objections as those which I have previously stated in speaking of condensed milk. These foods are largely employed and are highly valued by many physicians. I present for your examination a sample of Nestle's Food (the member of this group with which I am most familiar) which was kindly sent me by Messrs. Thos. Leeming & Co., of New York.

#### OTHER FOODS.

All infant's foods do not fall easily into the three groups just mentioned. Each manufacturer, of course, seeks to combine in his food the desirable qualities of other foods and to devise new ways of perfecting his product.

I show you now three foods prepared by Messrs. Reed and Carrick of New York: *Carrick's Soluble Food*, *Lacto-Preparata*, and *Lacto-Cereal Food*. *Lacto-Preparata* is composed of partly-digested milk without cereals; the *Soluble Food* consists of a mixture of milk partly digested by pancreatin, and wheat with its starch partly converted into dextrin and maltose. It is said to contain a quantity of free soda. The *Lacto-Cereal Food* is a new preparation of partly digested milk and cereals to which parched corn has been added to give a delicate flavor, and desiccated fruit to prevent constipation. You can now inspect these foods for yourselves. They are recommended by high authority. I obtained great benefit in one desperate case from the *Soluble Food*, but perhaps its alkalinity might be an objection to prolonged use.

I have prepared here also a sample of the *Lactated Food* of Wells, Richardson & Co., Burlington, Vermont. Although termed "lactated" it contains no milk. It seems to be a cereal food cooked and partly digested, to which a quantity of sugar of milk has been added. I have not yet used it.

The last preparation which I offer for examination to-day is *Wagner's Infant Food*, made by Wm. C. Wagner, Brooklyn, New York. It is said to be a wheaten milk-food, peptonized. My attention was recently drawn to it by the inquiry of a student who had observed its beneficial effects.

I have thus endeavored, gentlemen, to give you an insight into the principles on which infant foods are based, and to illustrate these principles by showing you certain familiar foods in the raw state and prepared for nursing, and each with a written sketch of its known ingredients. I have given the name and address of those firms who have made it possible for me to give you this elaborate illustrated clinic. I hope that you will not fail to test each class of foods in your practices. If the firms mentioned are as courteous to you as they have been to me, you can easily obtain the materials for study. The articles on infant foods in the text-

books which I have consulted are unsatisfactory. Their statements are not concise and well arranged, and elaborate scientific disquisitions crowd out the information which the practitioner needs. I shall be happy to present to members of the graduating class a reprint of this lecture, which is the result of much difficult research. I have not made analyses of the foods. My comments are based partly on the statements of the manufacturers, both in their circulars and in private letters to me; partly on the analyses of Professor Albert Leeds, of the Stevens Institute of Technology, Hoboken, N. J., a collection of reprints of whose writings in various publications was kindly sent me by the Doliber Goodale Co. (Mellin's Food); and partly on criticisms which manufacturers have made of the productions of other firms.

There is only one perfect infant food, the healthy mother's milk. When illness makes this unsuitable, one of the predigested foods or a food containing no milk may be substituted for a time, as a medicine. For continuous nourishment when breast milk cannot be obtained, I am at present in favor of the Torrefied Cereal Foods, given with fresh cow's milk. Most practitioners are acquainted with but one or two foods, and have but a hazy idea at best of the principles on which the different foods are based. Knowing but one or two foods, perhaps of one group, they must lose many little patients whose lives could be saved if the virtues of other foods were known and utilized. I have recently had personal experience of this in a child whose health, after all foods suggested by the doctor had failed, was restored by a food of an important class apparently unknown to him. I would urge you, if you have a child with whom one infant food disagrees, not to try others of the same group, but rather to turn to one of the other groups for a substitute. The selection of a suitable food is largely a matter of experiment. All foods issued by responsible firms have valuable properties and suit some infants. But the experiment should be guided by a knowledge of the principles of food manufacture on the part of the doctor.

With those physicians who "have no use for artificial foods," I am completely out of sympathy. If they have many infants to treat they must lose many who could be saved by artificial foods. Until a new race of more healthy mothers is produced in America, we must use infant foods, and we ought to appreciate the services to mankind, and to our profession, rendered by honest infant-food manufacturers.

There is a tendency among a certain class of physicians to stand aloof from the pharmacist and the manufacturer, who help, though perhaps in a more strictly commercial way, to promote the usefulness of medicine. I feel that this spirit of "I am holier than thou" is wrong and must hinder the growth of the physician in knowledge of things essential to his highest work. All who aid in the advance of true medicine should work together in harmony and mutual respect.

I desire, in closing, to thank the trained nurses of our hospital who have voluntarily undertaken the preparation of these food samples, led by a desire to familiarize themselves with every agent useful in the sick-room.

The Medico-Ethical Association of Manchester, England, proposes to draw up a "black list" of medical practitioners in the neighborhood whose conduct seems objectionable to the members of the Association. All physicians whose mode of practice is, in the opinion of a committee of the Association, unethical and derogatory to the honor, interests, and welfare of the profession, will be considered eligible candidates for the band of the listed. It is to be hoped that the association has a good-sized fund on hand to meet the expenses of libel suits, and to pay occasional damages for defamation of character.

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BALTIMORE, MARCH 19, 1892.

**Editorial.****THE PLASTER JACKET.**

The article on this subject, contributed to this issue of the JOURNAL, by C. C. Barnwell, is worthy of careful perusal and of preservation for future reference. The author claims the following as original points:

1. The use of the "quick-setting compound," of which the formula is given, as the most efficient combination for promoting rapid hardening of the plaster.
2. The invention and use of the knife-saw, as described in the paper.
3. The invention and use of the "zinc-strip" to protect the body from injury during the cutting open of the jacket.
4. The method of cutting open the jacket by the aid of a strong solution of salt in water and the knife-saw. By these means a hard jacket 18 inches long has been removed in five minutes.
5. The invention and the use of the "dusting-box," for filling the meshes of the leno strips with dry plaster.
6. The simplicity and cheapness of the outfit.
7. The plan of seating the child during application of the plaster bandages, and the use of chloroform to quiet it. Some may object to such use of chloroform on a child in sitting position, but it was endorsed, and the chloroform was administered in each case by careful professors of surgery from city colleges.
8. The protection of the lower limbs of the frightened child by a wrapper of muslin.
9. The invention and use of the drying oven, for quick drying of the jackets.
10. The method of making jackets smaller when they are too loose.
11. The method for stiffening and re-shaping of jackets which are broken or softened.
12. The idea of placing the child erect upon a common chair during the application.

13. The use of the "dry-bandage" to cover and protect the under-vest during the application of the plaster bandages.

14. The plan of smoothing the inside of the jacket by the use of the knife and knife-saw.

15. The avoidance of water-slaked plaster, and the use of unslaked plaster in the filling out and repair of jackets.

16. The employment of alum and salt for removing plaster from hands and clothing; the skin of the operator's hands being by this means kept soft and natural.

17. The use of the candle or of transmitted daylight for the detection of thin and weak spots.

18. The employment of pure paste for attaching cotton pads, front strips, etc., to the jackets.

19. The employment of the extension chair with cushions for laying down the adult patient.

20. The use of mint candy as a sedative and invigorator for children and adults. We begged to be allowed to omit this for adults, and to use other brands of candy; but the author was inexorable, and we were compelled to yield to evidence.

The author believes that the hand swing is superior to the chin and shoulder straps, especially for children.

The author has had very large experience in plaster jacket work during the last ten years and has shown us some very neat specimens, made according to the above methods, and greatly surpassing in lightness the jackets usually seen. The method here recommended is especially intended for the use of country practitioners and for home use by those who cannot afford to employ, or are out of reach of, professional jacket manufacturers.

We hope that this article will do much to counteract the tendency of the day to discard plaster-jackets as dirty and bothersome for the operator, and heavy, hot and irritating to the patient.

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#### GYMNASTICS FOR COLLEGE GIRLS.

The health of American girls of the upper class of society is not what it ought to be. No one seems to know exactly what is wrong with it, nor how the defect is to be remedied. The best authorities of the present day think that the over-tension and lack of repose in the nervous system (which reaches its climax in neurasthenia and hysteria) is due to a want of definite aim in life; a deficiency of suitable intellectual food; and an excessive development of the emotional nature—while the weaknesses of the pelvic organs, and the imperfect action of the digestive apparatus, are the result of a want of exercise of the muscles of the body, especially those of the trunk.

The first of these deficiencies is met by the higher education of women. That a prolonged course of college study is not in itself injurious to the health o



women in after-life, but rather the reverse, has been clearly shown by women who have passed through it. The emotional nature is tempered and the mind and nervous system are strengthened by the acquisition of regular and moderate habits and the contemplation of elevating themes. Moreover, the student awakens to a new interest in the activities of life. The danger of the college course lies in the tendency to measure the attainments of women by those, not of the best of her own sex, but of the best of the other sex; and in the habit peculiar to women of "keeping themselves up" on nervous energy long after the body is exhausted.

The second of these deficiencies is met in the best female colleges by the encouragement of a healthful style of dress, and by the frequent gymnastic drills. That dress-reform as advocated by its best exponents has already won the respect of the intelligent public and obtained many adherents among women of culture, is well known. Through the courtesy of the authorities of the Women's College of Baltimore, now one of the most prominent land-marks of this city, we were recently invited, in company with a number of physicians and ladies interested in education, to witness the gymnastic exercises of that college, which possesses among other fine buildings, a handsome and well-equipped gymnasium hall. The exercises, established under the supervision of Dr. Alice Chapman, the Professor of Physiology, were conducted by a competent Swedish teacher according to the most approved methods of "Swedish Movement," in which she had been trained. The precision with which the drills were executed proved the skill of the teacher and the enthusiasm of the pupils. Upon mature reflection we feel inclined to dispute the wisdom of those exercises which require a sudden output of great muscular energy and which lay heavy strain upon the organs of circulation and respiration. Experience teaches that the muscles, and the heart and lungs likewise, develop best under repeated moderate exercise. The person, whether male or female, of sedentary habits, who has not been continuously trained in gymnastics from youth up, receives little benefit from, and may be permanently injured by, muscular strains and shocks which the organs of the body have not been "built for" during years of growth.

Although most of the exercises at the Women's College were gentle and suitable to the needs of the students, and no effort was made to imitate the more daring or exhausting performances of male athletic clubs, nevertheless we venture to suggest that the feminine mind has still before it, in this department also, the ideal of men's attainment, and has not yet devised a complete system of gymnastics specially developed to meet the known needs of the American college girl's physical condition.

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### Correspondence.

#### WHO MAKES OPIUM SLAVES?

*Editor Maryland Medical Journal:*

Your editorial of the issue of March 5th, on "Who Makes the Opium Slaves," is both timely and good,

While it says many true things about the conservative practitioner, who uses opium to tide over trouble, ease pain, and perhaps to keep his patient out of the hands of the gynæcologist; and quite aptly quotes that distinguished gynæcological surgeon of Baltimore, for the statement that few, if any, come to him with pelvic troubles who are not more or less addicted to the opium habit. While he is too fair and high minded to write anything he is unable to prove or substantiate, I don't think the belief should be allowed to go abroad that general practitioners are the only ones who occasionally are too liberal in the use of anodynes. It has been my misfortune to have to battle with more than one woman who, after spendings weeks or months in our large cities under the care of gynæcological specialists—to return home vastly benefited, perhaps, as far as uterine or pelvic troubles were concerned—have awaked to the fact that they could not sleep, or walk, or be comfortable, because "they did not have the same kind of medicine they had been taking while away," and if it was not forthcoming on the doctor's recipe, you may be sure it was not very long before you found your patient quite satisfied with anything at your next visit.

I recall just now a married lady, who came into my hands after having spent three months under the care of one of Baltimore's most justly celebrated gynæcologist's, and who gave me and her family trouble enough for weeks to make me wish there were no specialists and one less doctor.

Again, within a year a patient of mine assured me after being several weeks in Baltimore that she was all right, as she had been home a month and had been comfortable, sleeping well, and free from pain, and would keep so, as she had Dr. —'s recipes, and was using his medicine night and morning. Suspecting all was not right, I asked to see them, and was shocked and surprised to find so intelligent and distinguished a man giving the woman one-fourth grain of morphia night and morning per orem, and who then supplied a suppository of opium and cocaine.

There can be no doubt that pelvic diseases offer to the busy practitioner more obstacles than any other kind, and that too often anodynes are resorted to. There is no excuse, in fact, for this, but there is in the minds of many a fear that a reference to a specialist will too often be a source of regret. It is true that abdominal surgery through the specialist has saved for me several valuable lives. It has also failed in several instances. Whilst I am not disposed to be too conservative, I am not, on the other hand, over-anxious to send my patients away from home until I am quite sure there is especial need of doing so. My only object in sending this letter is to show my concurrence in the opinion that busy general practitioners may and perhaps do make opium habitués, and to make the assertion that specialists in the gynæcological field are not guiltless in this respect.

There is need of a substitute for opium in pelvic pains, and I hope that ere long the profession will find some remedy that will relieve but not enslave.

Chestertown, Md.

Yours, W. FRANK HINES, M. D.

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### Medical Progress.

#### DEATH FROM IMPACTION OF FECES.

In the *Southern Practitioner*, February, 1892, a very interesting account of a fatal case of this nature is given by Dr. Buist, of Nashville. The patient was a well-known lady, 30 years of age. From youth she had been somewhat nervous and dyspeptic, though not evidently diseased. In 1890 she had influenza severely,

This was followed by neuralgia, dyspepsia, vomiting and constipation. Great debility and emaciation followed, attended by constant pain, like neuritis, in the head, trunk and limbs. In April, 1891, she partly convalesced, change of air being had and constipation being kept off by saline purgatives. On return home, however, she relapsed. Constipation and vomiting returned and twice brought her to the verge of the grave. There was now pain and tenderness along the left side of the abdomen over the descending colon. There was never any sign of peritonitis and very little tympanitis.

In September the pain and soreness excited by the enemata became unbearable and that means of nourishment was cut off. Both means of sustaining her were thus abolished, and she actually survived for twenty days without a particle of nourishment being introduced into her system, and without any evacuation from the bowels. She died on the 12th of October, 1891, the immediate cause of death being inanition.

Autopsy ten hours after death. Rigor mortis well marked; great emaciation. Abdominal cavity alone inspected. Surface of abdomen retracted and concave. Cavity entered by an incision on median line, and afterward cross, lateral incision. No adhesions, and no evidence of old or recent peritonitis. The small intestines were perfectly empty and collapsed, and looked like a coil of solid strings in the centre of the cavity. The large intestines were in places inflated and at others contracted. The stomach was extremely small; on laying open its walls no ulceration or abrasion was found, and there was not abnormal contraction at the pylorus. Liver small, but normal in appearance of surface and on section: gall-bladder contained an ounce or more of bile. The pelvic organs showed no sign of disease or displacement.

On examining the large intestines more closely, it was seen there were two distinct seats of contraction. The transverse and descending colon was then removed from the body, and inspected by the Academy of Medicine a few days after, and opened by a longitudinal incision. A dilatation existed about the sigmoid, a few inches above a contraction began and embraced six or eight inches, extending above the splenic curvature; the calibre in this part would not admit the little finger. Beyond in the ascending colon was another shorter section contracted, but not so much as the first. The distended portions or bowels held some very hard masses, but the bowel was quite empty as a whole. In a pouch at the lowest end of the contraction was a very hard fecal mass, which had so thinned the wall of the gut that perforation was about to occur. No ulcers and no cicatrices of former ulceration were visible; the walls in the contracted portions were greatly thickened, but no lesion of their tissue was apparent.

#### HÆMATEMESIS OF EARLY ADULT LIFE IN FEMALES.

At a recent meeting of the London Medical Society, Dr. Hood (*Lancet*, Feb. 20, 1892) read a paper on this subject, stating that from his own experience of the symptoms he would feel inclined, in a large majority of instances, to look upon it as but denoting a state of passive congestion, or stasis in the vessels of the stomach, and as being directly due to the anæmic condition so generally found accompanying this form of hæmorrhage, and not necessarily the result of ulceration. His personal experience is confined to about forty cases, and as supplemental to these he brought before the Society 155 cases collected for him by Dr. Goodall, late Medical Registrar to Guy's Hospital, from the clinical and pathological records of that hospital during a period of twenty years. It was noted that during that period no case is recorded at Guy's Hospital of a young girl succumbing to

an attack of hæmatemesis due to gastric ulcer. During the same period of twenty years sixteen patients were admitted suffering from a fatal peritonitis, the result of a perforating ulcer. Eight were men and eight were women. Ulcer of the stomach, regarded as causal in producing fatal peritonitis, is equally fatal to both sexes, and at much the same time of life. It was asked why it should not be equally causal with regard to hæmorrhage; clinically, severe hæmorrhage, excepting as the result of incipient cirrhosis, being markedly rare among males in early life. In discussing the etiology of hæmatemesis, cases would appear to fall into one of three fairly well defined groups—the period of early adult life, largely composed of anæmic girls, and comprising the cases referred to by the author; the period of middle life, in which the hæmorrhage is usually due to cirrhosis or ulceration, hæmorrhage from cirrhosis being much more frequent among the female sex than is supposed to be the case; and lastly, the period of advanced life, in which malignant disease and ulceration are about equally met with. In the course of the communication reference was made to two cases published by the late Dr. Murchison, in which a minute pore-like orifice was found leading into the bloodvessel. In both of these repeated attacks of hæmatemesis occurred before death. Hæmatemesis is so frequently found accompanying the anæmia of girl life that it would appear to be one of the results of that profound blood change, and when the gastric symptoms of anæmia are compared carefully with those due to ulceration of the stomach, a marked difference will usually be found to exist, the stomach symptoms of anæmia being generally of less intensity. The author considered the matter as one of importance, having special regard to treatment, for he maintained that in a very large majority of cases hæmatemesis occurring in early adult female life and complicated with anæmia, a treatment based on saline aperients combined with iron will give better results than one which would be urgently demanded if an ulcer of the stomach were the source of hæmorrhage.

#### GONORRHŒA AND CHILD-BEARING.

In an article upon gonorrhœal puerperal peritonitis (*North American Practitioner*, February, 1892), Dr. Robinson says:

The story of gonorrhœal puerperal peritonitis is simple. Young men acquire gonorrhœa and then marry before complete recovery. However, a man seldom ever gets rid of gonorrhœa, and he is capable of infecting a woman long after acquiring it. So soon as a man with gonorrhœa marries he may impregnate his wife and infect her with gonorrhœa at the same time. The gestation and gonorrhœa progress, although abortion from endometritis is apt to occur. Yet the pregnancy may continue to term, and at the same time the gonorrhœa may have advanced into one or both of the appendages, and have caused endo-salpingitis or pyosalpinx, or local peritonitis.

Now when the child comes to be delivered the mechanical and physiological disturbances initiate exacerbations of the old inflamed organ or rupture any pathogenic cyst existing. The re-excitation of the old or recent gonorrhœal tissue induces rapid increase of pathogenic material, and it or the material from a pathogenic cyst is forced into the abdominal cavity, and the result is a dangerous peritonitis, which often ends fatally. I have often noticed that women with gonorrhœal husbands will frequently have an early abortion and be left with a good deal of pathology in one of the appendages, which never fully clears up. As years go on they will occasionally become pregnant, because the other appendage has recovered sufficiently to functionate. Sometimes a gestation has the effect of absorbing most of the old exudate on the diseased appendage, especially if it be of

long standing. Such cases seem to escape gonorrhœal puerperal peritonitis. In fact the couple have really become acclimatized, or have worn out the pathogenic effect of the old gonorrhœa.

But most of these kind of couples in my experience are those of one child or sterile after early abortion. Modern investigations have brought to light much knowledge in regard to rupture of pathogenic cysts at labor, or gonorrhœal puerperal peritonitis. And I claim that many of these pathogenic cysts are due to gonorrhœa.

#### ANCIENT HINDU VACCINATION.

At a meeting of the Epidemiological Society (*Lancet*, February 29, 1892), Dr. Pringle quoted a remarkable passage from an ancient Hindu work, which showed that true vaccination was known and practised in India centuries before the birth of Jenner: "The small-pox produced *from the udder of the cow* will be of the same mild nature as the original disease. . . . the pock should be of a good color, filled with a *clear* liquid, and surrounded by a circle of red. . . . There will be only a slight fever of one, two or three days, but no fear need be entertained of small-pox so long as life endures." Pasteur's attenuation of virus by successive cultures has been applied in India for hundreds of years to inoculations with variolous lymph, which the document in question directed to be taken from "the most favorable cases," and he has seen series of such selected inoculations in which there was no general eruption, and the local phenomena were scarcely distinguishable from those of vaccination.

#### COMPLETE SUBCUTANEOUS EMPHYSEMA.

On November 30th, 1891, I was called to see a little boy, between 5 and 6 years old, who presented the following appearance. His neck, cheeks, and chest, arms, legs, and trunk, were swollen to an enormous size, so as to resemble a series of huge bladders. His eyes were quite closed up, and his head and neck formed a uniform inflated mass. The scalp was blown out in front and at the sides; the chest and back bulged out like great air cushions, which sank in on pressure for over an inch. The scrotum was inflated to the size of a large ostrich egg. Audible crackling could be elicited all through.

I learned that the boy had whooping-cough, and that after a fit of coughing, his mother noticed his neck below the jaws a little swollen. The swelling increased, and within two days his appearance was as above described. I punctured the most inflated part of the chest, but the amount of air that escaped was inappreciable. He was in a very weak condition when I saw him, with faint, whiffy breathing, sordes on the teeth, and extremely small pulse. He died three days after. The air seemed to have travelled by way of the mediastinum into the neck and from thence over the whole body.—George Croker, M. D., in the *Brit. Med. Jour.*, February 13, 1892.

#### THE ORDINARY WATER-BED AS A MEANS OF AFFECTING THE TEMPERATURE OF THE BODY.

I have for some years used the water-bed as a means of heating the human body during collapse, with such extraordinarily good results that I venture to call the attention of the profession to it, without claiming that no one else has done the same thing.

In cases of collapse and subnormal temperature occurring during advanced stages of typhoid fever, the severe forms of bronchitis, etc., etc., I have been accustomed to employ an india-rubber water-bed, and half the width of the ordinary mattress. It is placed upon the bed, alongside of the patient, partially

filled with water at a temperature of 140° to 150° F., and covered with blankets, upon which the patient is laid. The weight of the body carries it down and forces the water up at the sides, so that the person is partially surrounded by the heated water. The mass of the water, and the protection of the blankets, prevent the loss of heat, so that the mattress keeps hot for many hours. Within a few days I have had an example of the power of the hot water mattress. The patient, in the early part of the fourth week of typhoid, went into a collapse, with subnormal temperature and profuse sweating. At the time when the water-bed was put on his mattress his temperature was 97° F. There was some delay in getting the hot water; probably three-quarters of an hour elapsed before the man was put on the bed, and his temperature had fallen to 95.2° F. Within twenty minutes the temperature had gone up to 97.5° F., and afterward was normal. When the heat of the body has reached 98.5° F., the patient may be lifted off and laid alongside of the water-bed, which being covered by the same blankets as are over him will keep the temperature up to the normal.

The success which I have had in heating the body with the contrivance suggests that the water-bed may also be used instead of the cold bath for reducing temperature. All that would be necessary would be to have the water-bed supplied with two nozzles, instead of the ordinary aperture, and an india-rubber tubing or hose fastened to each nozzle, connecting the one with the spigot, the other with the outlet of the neighboring bathtub or stationary washstand. In this way, without labor or trouble, water of a constant temperature of 40° to 50° F., at least in winter, could be kept in the bed, and it would be very easy to run the water through ice if it were necessary to get further lowering of the temperature. I have not tried this method of cooling the body; but my present hospital practice not affording me much opportunity to study typhoid or other fevers, I venture to call the attention of the profession to the matter.—Dr. H. C. Wood, *University Medical Magazine*, March, 1892.

#### PLEURISY.

℞.—Potassi acetatis,	gr. xv.
Spt. atheris nitrosi,	3 ss.
Vini ipecacuhana,	gtt. iij.
Syr. tolutani,	3 s.

M. Sig. To be taken four times daily. (In subacute pleurisy.)—Da Costa.

℞.—Tinct. opii deodorata,	gtt. xx.
Tinct. digitalis,	gtt. xvj.
Syr. pruni virginia,	℥ j.
Aqua,	℥ iss.

M. Sig. A teaspoonful every 3 hours for a child eighteen months old. (In first stage).—J. Lewis Smith, *Ex.*

#### ORBITAL HÆMORRHAGE IN CHILDREN.

At a recent meeting of the Ophthalmological Society (*Lancet*, Dec. 26, 1891), Dr. Spicer read a paper on Orbital Hæmorrhages in Young Children, occurring beneath the periosteum in the course of infantile scurvy, the disease being generally known as scurvy rickets. Hand-reared infants were the subjects of the malady, and were generally between six and eighteen months of age. After a period of ill health, spontaneous hæmorrhage took place beneath the periosteum in various parts of the body, sometimes, but not always, during an attack of rickets. In the orbit the hæmorrhage occurred either as a line of blood-staining at the orbital margin or as a large effusion, producing displacement of the eye and of the upper lid, the form assumed being due to the anatomical disposition

of the parts in the orbit. The hæmorrhage subsided rapidly at first, but did not disappear entirely, the eye being left prominent for many months. The treatment was essentially that of scurvy; in addition to the ordinary food, juice of fresh meat, a little fruit or vegetable, cod-liver oil, or cream should be given. The slighter cases recovered rapidly; the more serious ones were slow in progress, and often proved fatal.

#### ARTIFICIAL RESPIRATION IN CYANOSIS FROM PLUGGING OF THE BRONCHIAL TUBES.

The present frequent allusion to the good effects of oxygen inhalation in cases of pneumonia and bronchitis urges me to call attention to a further aid I have now and then in the past resorted to with advantage. I shall merely allude to one case.

Many years ago I attended a medical friend, aged 65, for bronchitis. This rapidly became "suffocative" in character, and cyanosis came on. I performed artificial respiration (Sylvester's mode), on two occasions for about half an hour each time, and undoubtedly saved his life. This artificial respiration not only supplemented the exhausted respiratory force, more especially that of expiration, but enabled my friend to get up large plugs of mucus which prevented the ingress of air.

In another case where emphysema was marked, I tried, I think with distinct advantage, a Martin's elastic bandage around the chest. Again, where coughing is unavailing to get up accumulated secretion, and emesis is risky or cannot be produced, it will often be found that a strong sneeze produced by a good pinch of snuff will sometimes do a great deal of good.—Dr. James MacMunn, in the *Brit. Med. Jour.*

#### Medical Items.

The night medical service of New York is dead. The same service thrives in Paris.

The American Medical Association has nearly six thousand members, New York standing first in number of members and Illinois second.

Any one sending the following numbers of this JOURNAL: Vol. XXIV, 1890-91, Nos. 1, 9, 12; Vol. XXVI, 1891-92. No. 1, will be paid ten cents for same.

Seventeen mummies, recently purchased at a cost of \$200,000 by the Berlin Museum, have been shown to be of recent manufacture and the handiwork of some wily Arabs of Alexandria.

If a physician undertakes the care of a patient he is legally obliged to use his best care and skill irrespective of the question of his fees—such is the decision of a New York court.

Chicago physicians have started an organization representative of the entire profession for the purpose of entertaining members of the profession visiting the World's Fair. A medical headquarters will be established at a central general utility point. Special courtesies will be extended to special visitors.

Mrs. Halle T. Dillon, daughter of Bishop B. T. Tanner, is the first colored woman physician to pass the Alabama State medical examination, which was a written one and occupied ten days. Dr. Dillon, after passing with a high average, now occupies the position of resident physician at the Tuskegee (Alabama) Institute.

The sitting Virginia Legislature has done away with the title of Lunatic Asylum as applied to each of the four State institutions for the medical treatment of the insane patients in them, and substituted the word *Hospital* in its stead. This has long been a desirable change, for oftentimes there is *much in a name*.

We were sorry to lose Prof. Stephens for even a short time, last month, on account of his unfortunate accident in fracturing his clavicle. It is said that his obstetrical manikin, "Betsey," was confined during his illness, and delivered by some of the students. This was the first time in her three thousand confinements that the Professor did not attend her.—A joke from the University of Tennessee.

A magnificent microscope has just been completed at Munich for the Chicago Exposition, at a cost of \$8,750. It possesses a magnifying power of 11,000 diameters; with the oil immersion it can be increased to 16,000. Electricity furnishes and regulates the force of light, which, placed in the focus of a parabolic aluminum reflector, reaches an intensity of 11,000 candle-power.—*Med. Visitor*.

The Florida State Medical Society will hold its Annual Session during April of this year in Key West. It is proposed that on adjournment of the session the Society and its guests shall take a trip of a few days to Havana. The committee of arrangements are arranging with the Steamship Company for a very cheap *first-class* trip, which will no doubt be very enjoyable.

A board of officers will be convened in Washington, May 2nd, 1892, for the purpose of examining applicants for admission to the grade of Assistant Surgeon in the U. S. Marine-Hospital Service. Candidates must be between twenty-one and thirty years of age, graduates of a respectable medical college, and must furnish testimonials from respectable persons as to character. The following is the usual order of the examination: 1, Physical. 2, Written. 3, Oral. 4, Clinical. In addition to the physical examination, candidates are required to certify that they believe themselves free from any ailment which would disqualify for service in any climate. The examinations are chiefly in writing and begin with a short autobiography by the candidate. The remainder of the written exercise consists in examination on the various branches of medicine, surgery and hygiene. The oral examination includes subjects of preliminary education, history, literature, and the natural sciences. The clinical examination is conducted at a hospital, and when practicable candidates are required to perform surgical operations on the cadaver. Successful candidates will be numbered according to their attainments on examination and will be commissioned in the same order, as vacancies occur. Upon appointment, young officers are as a rule first assigned to duty at one of the large marine hospitals, as at Boston, New York, New Orleans, Chicago, or San Francisco. After four years service, Assistant Surgeons are entitled to examination for promotion to the grade of Passed Assistant Surgeons. Promotion to the grade of Surgeon is made according to Seniority and after due examination as vacancies occur in that grade. Assistant Surgeons receive sixteen hundred dollars, Passed Assistant Surgeons eighteen hundred dollars, and surgeons twenty-five hundred dollars a year. When quarters are not provided, commutation at the rate of thirty, forty, or fifty dollars a month, according to grade, is allowed. All grades above that of Assistant Surgeon receive longevity pay, ten per centum in addition to the regular salary for every five years service up to forty per centum after twenty years service. The tenure of office is permanent. Officers travelling under orders are allowed actual expenses. For further information or for invitation to appear before the board of examiners, address Walter Wyman, Supervising Surgeon-General, Washington, D. C.



# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

The Recent Incursion of Typhus Fever at New York. By R.M. Wyckoff, M. D., Brooklyn, N.Y. 463

What Little Inconvenience is at Times Caused by Large Foreign Bodies in the Conjunctival Sac. By F. M. Chisolm, M. D., Baltimore. 465

The Medical Bill. . . . . 466

### SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting Held Feb. 5, 1892., Free Dispensaries, or The Physician and the Poor. External Perineal Urethrotomy without a Guide. . . . . 469

### EDITORIAL.

The Medical Bill. . . . . 473

Danger to the Library of the Surgeon-General's Office. . . . . 473

REVIEWS, BOOKS AND PAMPHLETS. . . . . 474

### MEDICAL PROGRESS.

The Constant Electric Current in Intestinal Occlusion.—The Influence of Forests on Climate.—The French Law to Protect Infants.—The Bacteria of Cheese.—Inter-Partum Hour-Glass Contraction in a Case of Twins.—Ether as a Stimulant at the Temperance Hospital.—The Causation and Treatment of Piles.—The Function of the Hair-Tufts in Man.—Infective Inflammation of the Vesiculæ Seminales. . . . . 475

MEDICAL ITEMS. . . . . 483

## Original Articles.

### THE RECENT INCURSION OF TYPHUS FEVER AT NEW YORK.

BY R. M. WYCKOFF, M. D., OF BROOKLYN, N. Y.

The recent importation of typhus fever into the harbor and city of New York is a calamity of no small moment. The loss of life has already been considerable from that cause; many persons have been exposed, imperiled and put to loss, suffering and inconvenience. And all this has, apparently, occurred to no good purpose and without cause. If the statement of the official guardians of the port of New York does not err, the serious injury of which we treat was brought about by the false report and perjury of one or more ships' officers, at the time of their passage through quarantine. A grave responsibility rests somewhere between the parties in question, and will no doubt be carefully inquired into in the interest of the public health. If "accidents" of this nature are repeated, it may become necessary not only to have our own governmental inspectors at the European ports of emigration, but also to have medical representatives who shall accompany the steamers that bring us their hundreds and thousands of endangering personalities, from the very homes of fever, famine and overcrowding. In the sixties, the fear of Asiatic cholera led to some intelligent legislation, along our seaboard, concerning sanitary measures; but no lively public interest in such measures has been manifested during the past decade. It is almost painful to contemplate the apathy that reigns in all our legislative halls, National as well as State, regarding prevention. It invites the sinister reflection that only by the deaths of a few

hundreds, by an uncalled-for epidemic, can a proper degree of official vigilance and precaution be evoked. Human sacrifices seem to be demanded.

The present importation of ship-fever dates from January 30, the time of arrival of the "Massilia," a tramp-steamer from Italy. This vessel brought to these shores 714 steerage passengers, over 250 of whom were Russian exiles, mostly Hebrews. These unfortunates had not only been driven from their homes, but had been buffeted about, while seeking to find a foothold in some part of Europe and Asia Minor, until the time when passage to America was secured for them from Italy. There were three deaths in the steerage during the voyage, but it was claimed that the cases were non-contagious. When the immigrants were received at the Ellis Island station in the harbor, ten of the Russian Hebrews were reported as sick from typhoid fever or pneumonia. Six were detained as paupers and therefore not entitled to remain in this country. Those who were permitted to go on shore were not sick, in the opinion of the medical inspectors, although some of them were reported as greatly enfeebled by the voyage and by the alleged poor treatment on the steamship. The 450 Italians were landed without delay and scattered in many directions. Cases among Italians or Russians have since been reported from as many as eight distinct States. The labors entailed upon the health authorities of New York City were most onerous. In three weeks immediately following the discovery that typhus had been imported, 139 cases and eleven fatalities were on their records as confirmed officially, and provided for in some way chiefly by removal to the contagious disease hospitals or by isolation. Fumigation by heat was practised as far as practicable with the belongings of the immigrants still to be found in the city. A systematic inspection of the lodging houses and their 5,000 inmates was among the earliest duties. An appropriation of \$12,000 became necessary to provide additional accommodations and nursing at the typhus fever pavilions on North Brother Island. A corps of fifteen medical inspectors watched the suspected places and persons, even making sure of the proper conduct of funerals and interments.

Theoretically, typhus fever is a disease having fewer menacing qualities than variola, and yet the New York authorities practically combatted it with about the same weapons, barring only vaccination. In former epidemics in New York, a very considerable sickness-rate and mortality have befallen the medical men and other attendants in the fever-wards. Roughly stated, about fifty per cent. of the hospital internes formerly took the fever, and fifty per cent. of those sickening with the fever were sacrificed. Very few of those internes who could not be removed to their homes, at the onset of the attack, left the hospitals alive. Thus far in the present epidemic, the medical and inspectorial staffs have been spared. Of the nurses and sanitary police, three or four only have contracted the fever, and none have died. The epidemic appears to be milder than in past years, although there must always be some doubt regarding the total number of sick and dead from the current outbreak, for the reason that some hundreds of exposed persons were scattered to the four points of the republic, before the nature of the importation was discovered. We suppose there are thousands of medical men, who have been in practice twenty or twenty-five years, who never yet sat face to face with a case of typhus. It is probable that some of our inland practitioners may this year have their first opportunity to exert their diagnostic skill in regard to the "dusky spots" of typhus.

Anomalous cases of fever in the persons of Russian Jews or Italians, newly arrived, may well excite suspicion and caution on the part of those who have not before had to do with the old time "ship-fever" or "famine-fever," as typhus has

variously been called in the earlier history of American quarantine against imported pestilences. It may serve as an illustrative clue to the comparative rarity of this fever in past times when it is known that in the wide bounds of that great commonwealth, Michigan, during a period of five years, just one case of typhus was known to have existed, and that was the case of an imported Finlander. Even in New York City there has been six or seven years interval between the times of occurrence of indigenous cases of the fever. So far as known the imported cases were the only ones and sanitary measures were competent to prevent any secondary cases. This experience speaks volumes on behalf of local health administration in the hands of a well managed medical staff.

532 Clinton Avenue.

### WHAT LITTLE INCONVENIENCE IS AT TIMES CAUSED BY LARGE FOREIGN BODIES IN THE CONJUNCTIVAL SAC.

BY F. M. CHISOLM, M. D., OF BALTIMORE.

When daily experience shows us the extreme suffering of those who accidentally get a small cinder or particle of dust in the eye, it is curious to note the little irritation that is caused by the presence of some much larger foreign substances that gain an entrance to the retro-tarsal fold of the upper lid. The size of these foreign bodies is at times very large and their shape quite varied. How they ever got there, and why they should not cause suffering, more or less severe, is hard to understand. Pieces of wood, large seeds, different kinds of beads, etc., not only find lodgment under the lid, but often remain there for long periods, weeks and even months, their presence exciting but little irritation. They cause an elevation in the lid resembling in appearance a tarsal tumor. This painless swelling is thought a trivial matter and consultation with a physician is delayed because of the little inconvenience from the intruding body. I have seen large foreign bodies that have been overlooked by the family physician, who thought the trouble only a mild conjunctivitis, the result of a slight blow in the eye or of a cold, to be treated by an astringent lotion. The case I relate is noteworthy because of the size of the foreign body, the length of time it remained under the lid and the very slight amount of irritation its presence had occasioned.

A little girl 9 years of age was brought to me from the country in February. Sometime during the previous October she had been struck in the right eye; by what, she could not tell. She did not complain very much of the eye, but the parents perceiving that it was a little congested, sent for their family physician. He called it traumatic inflammation of the conjunctiva, and some mild astringent wash was given. The eye improved under its use. Not long afterwards there was noticed, what had previously escaped observation, viz., a prominence on the child's right upper lid. The parents expected that it would disappear spontaneously, so the swelling caused them but little anxiety, especially as it was not accompanied by pain. Several days before I saw the child, a firm, dark substance suddenly made its appearance at the inner canthus of the eye. This aroused anxiety and brought them to the city to seek advice. On examination the lid conjunctiva only was found congested, the appearance of the ball being normal. The inner angle of the lids was occupied by a dark object, the end of which popped out as the lids were separated from the eyeball. It was found to be a piece of round twig,  $\frac{7}{8}$  of an inch long by  $\frac{1}{8}$  of an inch in diameter. This had been under the lid for nearly four months. Before it had changed position, mere eversion of the lid would not have exposed the intruder, as its location was in the cul de sac,

behind the tarsal cartilage. In some way, probably by the child rubbing its eye, the twig had had its horizontal direction changed, with the end slightly projecting from under the upper lid. Its escape had been prevented, however, by the lower lid, under which the end had caught at the inner canthus.

114 W. Franklin Street.

#### A BILL

*Entitled an Act to repeal and re-enact with additions and amendments, sections 39, 40, 41, 42, 43, 44, 45, 46 and 47, of Article 43, of the Code of Public General Laws, title "Health," sub-title "Practitioners of Medicine."*

Section 1. Be it enacted by the General Assembly of Maryland, That sections 39, 40, 41, 42, 43, 44, 45, 46 and 47, of Article 43, of the Code of Public General Laws, title "Health," sub-title "Practitioners of Medicine," be and the same are hereby repealed and re-enacted with amendments and additions so that the said sub-title shall read as follows:

39. And be it enacted, That every person, not now practicing medicine and surgery, who shall hereafter begin to practice medicine and surgery in any of its departments, except dentistry, in the State of Maryland, shall possess the qualifications required by this Act.

40. From and after the first Tuesday in May, eighteen hundred and ninety-two, there shall be and continue to be two separate Boards of Medical Examiners for the State of Maryland, one representing the Medical and Chirurgical Faculty of the State of Maryland and one representing the Maryland State Homœopathic Medical Society of the State of Maryland; each board shall consist of seven members, and each of said members shall serve for a term of four years or until their successors are appointed and qualified, each board to have exclusive right to examine, pass upon the qualifications of and license its own applicants, said members of the first or old school board to be appointed by the Medical and Chirurgical Faculty of Maryland, of which two shall be from the counties of the Eastern Shore and five from the Western Shore, of which latter number two shall be from the counties west of the Blue Ridge Mountains; and said second or Homœopathic Board to be composed of seven physicians, appointed by the Maryland State Homœopathic Medical Society, of which three shall be residents of Baltimore and four of the State at large; the appointees shall be physicians actually engaged in the practice of medicine and of recognized ability and honor; the term of office of each board shall commence on the first Tuesday in May, 1892; no member of any college or university and no physician having a pecuniary interest in the trade of pharmacy shall be appointed to serve as a member of either said boards; vacancies occurring in such for unexpired terms shall be filled by the board, in accordance with the foregoing provisions of this section, and for expired terms in same manner as for first appointees.

41. That each Board of Medical Examiners shall meet within thirty days after receiving official notice of their appointment; at the first meeting of each of the boards respectively, an organization shall be effected by the election from their own membership of a president and a secretary; for the purpose of examining applicants for license each of said boards of medical examiners shall hold one or more stated or special meetings in each year, due notice of which shall be made public at such times and places as may be determined by the members thereof respectively; at said stated or special meetings a majority of the members of the

board shall constitute a quorum thereof; each of said boards of Medical Examiners shall keep an official register of all applicants for examinations for a license to practice medicine and surgery in this State; said register for license shall show the name, age and last place of residence of each candidate, the school from which he or she may have graduated, and whether such applicant was rejected or licensed under this Act, but such matters shall not be written in said register or made public until after the examination.

42. At the first meeting of an examining board, or at stated or special meeting held subsequently, suitable provisions shall be made by each of the examining boards to prepare a schedule of written examinations upon anatomy, physiology, chemistry, surgery, practice of medicine, materia medica, therapeutics, obstetrics, gynecology, pathology, medical jurisprudence and hygiene, and shall require the same standard of excellence from all candidates; in the department of therapeutics and practice the questions shall be in harmony with the tenets of the school selected by the candidates, the standard of acquirements therein to be established by each board for itself; whenever members of any boards are necessarily absent from meetings held for the examination of applicants for license, suitable temporary provision shall be made for thorough examinations in each and all of the aforesaid subjects by the members present; the examination shall be fundamental in character and such as can be answered in common by all schools of practice; the votes of all the examiners present shall be "yes" or "no," written with their signatures upon the backs of the examination papers of each candidate for the respective branches.

43. That all persons commencing the practice of medicine or surgery in any of its branches after the first Tuesday in May, (May 3rd) shall make a written application for license to the President of either Board of Medical Examiners which said applicant may elect, together with satisfactory proof that the applicant is more than twenty-one years of age, is of good moral character, has obtained a competent common school education, and has either received a diploma conferring the degree of doctor of medicine after having attended a three years course from some legally incorporated medical college in the United States, or a diploma or license conferring the full right to practice all the branches of medicine and surgery in some foreign country, and has also both studied medicine three years and attended three courses of lectures in different years in some legally incorporated medical college or colleges prior to the granting of said diploma or foreign license; provided that two courses of medical lectures, both of which shall be either begun or completed within the same calendar year, shall not satisfy the above requirement; that this condition shall not apply to students in their second year in a medical college, nor to physicians who shall be practicing medicine at the time of the passage of this Act; such proof shall be made, if required, upon affidavit; upon the making of said application and proof and payment of fee as provided, the president of the board to whom such application was made, if satisfied with the same, shall direct the secretary thereof to issue to said applicant an order for examination, and when said applicant shall have passed an examination as to proficiency satisfactory to said board, the president shall grant to such applicant a license to practice medicine and surgery in the State of Maryland.

44. That all examinations shall be conducted in such manner that the name, school of graduation and preparatory training of said applicant shall not be made known to the Board of Examiners until his examination papers have been graded; an applicant receiving a majority of the votes of the board before whom the appli-

cant appears shall be considered to have passed a satisfactory examination and entitled to the license of said board.

45. That a fee of ten dollars shall be paid to the Secretary of the Board, before whom the applicant appears, before such examination is had, which said fee shall be applied by said board toward paying the expenses of said board.

46. That the board shall refuse to grant a license to any applicant who may be radically deficient in his examinations in any essential branch; provided, that in case of failure, at any such examination, the candidate, after the expiration of one year from his rejection, shall have the privilege of another examination by the board to which application was first made.

47. That every license to practice medicine and surgery issued pursuant to the provisions of this Act shall be subscribed by the President and Secretary of the Board before whom applicant passed, and by each medical examiner who reported the licentiate as having successfully passed said examinations; it shall also have affixed to it, by the person authorized to fix the same, the seal of said Medical and Chirurgical Faculty of Maryland, or of the Maryland State Homœopathic Medical Society, as the license may require; every such license shall be in following form:

To all whom it may concern, greeting:

Be it known that \_\_\_\_\_, on the \_\_\_\_\_ day of \_\_\_\_\_, A. D., \_\_\_\_\_ having offered to us satisfactory proof that \_\_\_\_\_ was more than twenty-one years of age, and had received a proper preliminary education; that \_\_\_\_\_ had attended three full courses of medical instruction, the last courses at \_\_\_\_\_, in \_\_\_\_\_, in the years of \_\_\_\_\_, and had received from the \_\_\_\_\_ of \_\_\_\_\_ the degree of doctor of medicine; we thereupon gave a written order for the examination of said \_\_\_\_\_, before one of the Boards of Medical Examiners of the State of Maryland; that the said \_\_\_\_\_ was fully examined before our said board and found proficient and qualified to practice medicine and surgery by the examiners whose signatures are hereto attached; we, therefore, have granted to said \_\_\_\_\_, this our license to practice medicine and surgery in the State of Maryland as a physician and surgeon, and have caused the names of the President and Secretary of our Board and said examiners to be subscribed, and the seal of our society to be affixed hereto, and have also caused this license to be recorded in book \_\_\_\_\_ of medicinal licenses, on page \_\_\_\_\_.

Witness our hands and seal of our said Society, this \_\_\_\_\_ day \_\_\_\_\_ A. D., 18 \_\_\_\_\_. —President; —Secretary; —Examiners.

Sec. 48. And be it enacted, that any person receiving a license from either of said boards shall file the same, or a certified copy thereof, with the Clerk of the Circuit Court of the county or city in which he or she may practice, and it shall be the duty of said Clerk to register the name of such person, and the president of the board signing the same in a book kept for the purpose, as a part of the records of his office; and the number of the book and the page therein containing said recorded copy shall be noted in the body of the license; said record shall be open to public inspection, under proper restrictions as to their safe keeping, and in all legal proceedings shall have the same weight as evidence that is given to the record of conveyances of land; the fee for each registration shall be one dollar, to be paid by the person whose license is registered.

Sec. 49. And be it enacted, That this Act shall not apply to Commissioned Surgeons of the United States Army, Navy or Marine Hospital service, to physicians or surgeons in actual consultations from other States, or to persons temporarily practicing under the supervision of an actual medical preceptor.

Sec. 50. And be it enacted, That any person to whom the provisions of this Act

applies, practicing or attempting to practice medicine or surgery in this State, without first having obtained the license of one of said Boards of Medical Examiners, shall be guilty of a misdemeanor, and shall pay a fine of not less than fifty dollars, nor more than two hundred dollars, for each offense, or in default of payment shall be confined in the city or county jail until the fines and costs are paid, and shall be debarred from recovering compensation for services rendered as such physician or surgeon.

Sec. 51. And be it enacted, That all Acts, or parts of Acts now existing, not in accordance with the provisions of this Act, are hereby repealed.

Sec. 52. And be it further enacted, That the provisions of this Act shall not apply to any midwife or person who may render gratuitous services in case of emergency.

Sec. 53. And be it further enacted, That it is provided that said board shall make a written report to the Medical and Chirurgical Faculty of Maryland and to the Maryland State Homœopathic Medical Society every two years.

Sec. 54. And be it further enacted, That this Act shall take effect from the date of its passage.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 5, 1892.

The 261st regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

*Dr. W. B. Platt* read a paper on FREE DISPENSARIES, OR THE PHYSICIAN AND THE POOR. Dr. Platt, in his dispensary work, adopts as nearly as possible the following plan: Inhabitants of certain squalid alleys well known to him are treated without question. The destitute and forlorn whose aspect is unmistakable to one having dealings with the poor, come in first of all for treatment. Mechanics, artisans or laborers out of work and out of money, and the families of drunken and worthless men, are all entitled to free treatment. Adults who have to pay for their board and lodging out of wages less than \$5 per week are treated free. House servants earning \$10 and \$12 per month can and do pay physicians for advice.

*Dr. I. E. Atkinson* said: This subject, as Dr. Platt has pointed out, bears upon the patients, the physicians in attendance and the profession at large. The abuses of dispensaries is a world-wide complaint and the difficulties that stand in the way of correcting them are almost insuperable. In the first place, the presence of a person at the dispensary is a confession of poverty, and when questioned in regard to his financial condition nearly every patient is prepared to say that he is unable to pay the fees of a physician. Occasionally one encounters patients who, when questioned, avow their ability to pay, and are properly excluded. I think that the evils of dispensary service are more apt to be developed in dispensaries other than those in which patients are used for clinical purposes. The presentation before a class of students is, to persons who are not degraded, a very disagreeable procedure and they will refuse to come again unless compelled by necessity.

What kind of patients are entitled to relief? Every one admits that the pauper is the proper person. There is not so much unanimity of opinion with regard to the relief of those persons who are brought to that condition by their

own vices. Never mind what his faults, nor what his vices, nor how utterly beyond the pale of ordinary sympathy he is, as soon as he is sick he becomes a worthy object of charity. In this way medical charity differs from almost every other kind of charity. Dr. Platt mentions another class that especially appeals to my sympathy, viz., the wage-earner who makes \$10 per month. As to whether or not he shall pay, depends entirely upon how much he is called upon to pay. A fee of \$1 would be 10 per cent. of his income for the month and his medicine would cost perhaps 5 per cent. more. It may be that he should not be the beneficiary of a freedispensary, but of a provident dispensary, the absence of which in Baltimore I very much regret. I further believe that the man who earns \$1 or \$1.50 per day and supports his family is entitled to a modified relief. This man, by careful economy, is able to keep his family alive, but he cannot support them in comfort. Just as soon as a member of his family falls sick his expenditures are enormously increased, while his income remains the same or is diminished. If he himself falls sick the income stops while expenses increase. I think that one of the great needs is that modified form of charity which we recognize as a provident dispensary. This idea of a provident dispensary is not a new one. The individual pays into it so much per month and his membership entitles him to receive the services of good, intelligent physicians, who are properly paid for their services by the association, and gets his medicine at a reduced rate. Membership in the dispensary is only granted to those who receive a certain maximum of wages. Such dispensaries have been in existence in England for fifty years, yet the number is small. The justice of them, the propriety of them and the benefits to be derived from them are so manifest that it is difficult to understand why it is that such a limited popularity should be accorded to them.

That there is dreadful abuse in dispensary practice I am convinced, but that the abuse is not altogether on the part of the patients I am also convinced. There are few ordinary day laborers who feel able to pay the full fees of physicians and the prices of the pharmacist. Some do it from pride, some from principle, and some they know not why. But in case of continued sickness it is absolutely impossible for them to pay physicians fees and they are forced into incurring debts which they know they cannot pay. I am an advocate of that form of relief which shall not pauperize the individual but will enable him to secure for himself and family proper professional advice and necessary medicines without too great a strain on his purse.

*Dr. Platt:* I think Dr. Atkinson's point in regard to there being less abuse in dispensaries where patients are used for clinical material is well taken; and yet the great howl that has gone up recently has been on account of a dispensary which is used almost exclusively for purposes of instruction. I think there are many persons who are perfectly shameless about getting charity. There is generally a look about a person who lives poorly and miserably that enables you to spot them as quickly as you can tell a wharf rat from a common one. They have poverty written all over them.

There is a middle class, whose earnings are not much, yet who have deposits in the savings bank and ought to pay. There are physicians who would make a reasonable number of visits at half price and they can get rates reduced at the pharmacists. As to having patients pay at a dispensary, that has been tried. The only thing that has not been tried thoroughly is to carefully investigate each patient by a visit to his home. I have had people come to me at the dispensary who owned houses and had bank accounts, others with a large number of children, all receiving good salaries.



I think the key to the whole matter is to look up each individual and see whether or not he can pay. I think there are very few physicians in this room who charge all persons alike. If a patient cannot pay my full fee I treat him for less.

*Dr. Herbert Harlan:* I have had experience with different dispensaries ever since my student days. I believe that at the dispensary of the Maryland University, where patients are used for clinical purposes, there is very little imposition. It may be on account of the large class of students, for the tendency of people is not to go before a class of students. I have known a good many patients to go to that dispensary on other days of the week and to absent themselves on the days of the clinic. There is, however, quite a large class of people who like to hear their cases discussed. The Baltimore General Dispensary is not imposed on much because the physicians visit the patients' houses and see whether they can pay or not. The great abuse is undoubtedly in the special dispensaries. We have tried a good many devices to prevent those who ought to pay from receiving services free. One was for the physician to question them as to their ability to pay. Sometimes they answer yes, sometimes no. Some say they can pay but others who can pay are treated free. Here is the point that I want especially to raise here. At a specialty dispensary it is a daily occurrence for patients to say, doctor so and so, my family physician, sent me here to have my case treated.

Physicians themselves are not as particular about these things as they might be. We ask such people if they pay their family physicians and they reply, certainly we do. Then we refuse to treat them. We have tried in another way to prevent abuse, viz., by having a clergyman, who is regularly employed for the purpose, to go about the waiting room and question the patients and act as judge as to who shall or shall not be treated. This, I think, is a move in the right direction. We are indebted to Dr. Platt for calling our attention to this matter and we ought all to make an effort to do away with the abuses.

*Dr. I. E. Atkinson:* The physician who charges but small fees knows that in many cases his patients cannot pay the fees of a special practitioner. I frequently have had patients, who pay me, go to a special dispensary. They do not ask my opinion about it. They say they cannot pay specialist's fees. I think the standard in regard to this class of patients should be a little different from that of the class going to the general dispensaries.

*Dr. J. Edwin Michael* read a report of EIGHT ADDITIONAL CASES OF EXTERNAL PERINEAL URETHROTOMY WITHOUT A GUIDE, these cases being in addition to nine cases already reported by him in the spring of 1887.

*Dr. Platt* thought that considering the difficult nature of the operation the success of Dr. Michael was astonishing and very unusual.

*Dr. Robert W. Johnson* spoke on "A convenient and comprehensive method of Instrument Disinfection," and exhibited the apparatus which he devised and uses. Dr. Johnson boils everything except himself, his patient and the rubber tissue. He boils the ligatures, instruments, needles, gauze, etc., and also the trays which hold them. The boiler is plain tin, large enough to accommodate the trays, with spigot attached near the bottom. A nest of elongated trays of granite ware is found most convenient. Before leaving his office he goes over the instruments that will be required and puts them in a tray. The dressings to be used are put in another tray; and so on, and finally the trays are built up one upon another and all are put into the boiler, which is put in the back of the wagon. At the patient's house the boiler is filled up with boiling water, put upon the stove and boiled for 20 to 30 minutes, while the patient is being prepared

for operation. When ready for operation, the trays are lifted out by means of sterilized button-hooks. The boiler is put in an elevated position, a rubber tube attached to the spigot, and the boiled water is used for irrigation. It makes no difference whether knives or dressings touch the sides of the trays, for they are quite aseptic.

*Dr. Herbert Harlan* asked what means were taken to prevent the rusting of instruments in boiling. He had noticed the curious phenomenon that the steel blades of a set of knives with aluminum handles rusted more readily than those of knives with ivory handles.

*Dr. Chunn* asked *Dr. Johnson's* method of preparing his hands for the operation.

*Dr. Johnson*: By adding a slight amount of bicarbonate of soda to the water rusting of instruments during boiling is prevented. I sometimes use bichloride on my hands and sometimes potassium permanganate, cleaning it off with oxalic acid. The latter is probably the best method.

#### DECLINE OF POPULATION IN FRANCE.

The official figures and facts concerning marriages, births, deaths, and divorces in France during the year 1890 were made public to-day. The French Government is slow in gathering and formulating statistical information, but, on the other hand, its work in this line is done accurately and well.

The report just submitted is not of an encouraging nature. The deaths continue to outnumber the births, and the fact can no longer be concealed that the native population is diminishing with a degree of rapidity that is not effectively counterbalanced by immigration. The loss of population to France by emigration is a mere trifle, the total number of emigrants being less than 34,000 a year, and it is estimated that 64 per cent. of this number return to France within ten years to remain permanently.

There are, it seems to me, two grave causes for the diminution of the population of France. One is the harshness of the marriage laws, which throw a large number of annoying obstacles in the way of persons inclined to matrimony; the other cause is to be found in the standing army of more than 500,000 men. Army life prevents many men from marrying, and the enforced military service makes it impossible for many others to marry until late in life, for, after leaving the army, they have to find positions and careers which will enable them to support families.

In France marriages, births and deaths are attended by a host of expenses and formalities of a legal nature that are, to my knowledge, oftentimes a serious burden to the individual, particularly among the working and poorer classes.

I may also remark here that a citizen of the United States who weds or dies in France is, as a rule, unfortunate in his selection of a place for those events, as he or his heirs will speedily discover.—*U. S. Consular Report, January, 1892.*

*Dr. Hinton* recommends the following treatment to remove bone felon: Prepare a poultice of equal parts of powdered soap and desiccated salt (anhydrous sodium chloride), and enough balsam fir to make a mass. The mixture is applied twice daily for three days, when it will have made a hole to the bone, and "the core" is easily taken out. He has used the above in over a hundred cases with success.—*N. Y. Medical Times.*

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BALTIMORE, MARCH 26, 1892.

**Editorial.****THE MEDICAL BILL.**

We publish elsewhere in the present issue of the **JOURNAL** the Medical Bill now pending at Annapolis. The bill, with a few minor modifications, is a reproduction of the bill framed by the General Assembly of 1890, which failed to become a law through the act of Governor Jackson, who withheld his signature for reasons best known to himself, but not apparent to the profession of the State.

Whilst the present bill is not all that might be desired, it has many meritorious features and should it become a law will give to the profession and to the citizens of the State a guarantee of better methods of medical education and practice.

The bill has passed the Senate and now awaits the action of the House of Delegates.

In view of the lateness of the Session there is considerable danger that its passage through the House may be defeated by apathy and indifference. We, therefore, urge such members of the profession as are interested in the bill to write to their constituents in the legislature, urging them to push the bill through.

We have every reason to believe that the present intelligent Chief Executive, Governor Brown, will sign the bill if enacted by the General Assembly.

**DANGER TO THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE.**

Under the provision of the Army Appropriation Bill, reported by the Military Committee to the House of Representatives, the usual annual appropriation for the Library of the Surgeon-General's Office, U. S. Army, is cut down one-half—that is, it is reduced from ten thousand to five thousand dollars.

This proposal cannot fail to call forth a vigorous protest from the medical profession of this State and of the whole country. This medical library is a source of pride to the physicians of this country and has awakened the admiration of medical men throughout the civilized world. It is unrivalled in its completeness,

intelligent management and usefulness. Any weakening of its present efficiency would be no less than a calamity to the large number of physicians who by the most liberal arrangements are permitted to make use of its contents.

We are informed upon the best authority that, if the reduction of the appropriation proposed be carried through, the formation of a complete medical library at Washington, so successfully under way, must be stopped, all the new medical books and journals can no longer be purchased, and valuable works still lacking cannot be secured.

It may be necessary for the Government to retrench its expenditures, but surely it is unwise, short-sighted and false economy to check the progress and development of our great medical library by cutting down its modest appropriation, which is at present no more than sufficient to maintain the high standard of which we feel so proud.

Physicians are not prone to mingle actively in political matters or to endeavor to influence legislation. This is all the more reason why their voice of protest should now be heard. The Medico-Chirurgical Faculty will be called upon to present to the representatives of this State in Congress formal resolutions of protest, and doubtless other local medical societies will follow this example. Let all physicians and others who can exert any influence upon Representatives and Senators in Congress endeavor to prevent if possible the proposed reduction of the annual appropriation for the library in Washington.

### Reviews, Books and Pamphlets.

*A Manual of Operative Surgery.* By FREDERICK TREVES, F. R. C. S., Surgeon to and Lecturer on Anatomy at the London Hospital. In two octavo volumes containing 1550 pages, with 422 illustrations, mostly original. Per set, cloth, \$9; leather, \$11. Philadelphia, Lea Brothers & Co., 1892.

The manual begins with good, sound suggestions as to the condition and preparation of patients to be operated upon, and offers practical advice in the after-treatment of each operation. The author's style is peculiarly clear and simple in presenting, what he claims to do, merely the practical aspects of treatment by operation, and such parts of the surgeon's work as come within the operating room. The work is compiled with great care in selecting the most approved forms and methods of operating, and has kept pace with the rapid progress that surgery has made in the past few years, over 400 pages being devoted to the various operations by abdominal section. The subjects are concisely and graphically presented in language attractive and pleasant to the reader; the print large and clear; the illustrations are well executed and distinct. The work will undoubtedly serve its purpose, and deserves commendation.

*The Complete Medical Pocket Formulary and Physician's Vade-Mecum.* Containing upward of 2500 prescriptions; a special list of new drugs, with their dosage, solubilities and therapeutical applications; together with formulæ for suppositories for hypodermic medication; for inhalations; posological tables; account of disinfectants; urinary tests; etc. Collected for the use of practitioners by H. C. WILSON, A. M., M. D., Physician to German Hospital, Philadelphia. Price \$2, size to suit coat pocket, with flap. Philadelphia, J. B. Lippincott & Co., 1892.

*The Aseptic Closure of Long-Standing Sinuses Having their Origin in Tubercular Joints.* By H. AUGUSTUS WILSON, M.D., Professor of General and Orthopedic Surgery in the Philadelphia Polyclinic; Clinical Professor of Orthopedic Surgery in the Woman's Medical College; Clinical Lecturer on Orthopedic Surgery in the Jefferson Medical College. Pp. 9. By the same author:—

*Report of a Case of Spina Bifida, with Partial Motor and Sensory Paralysis of both Extremities, etc.* Reprinted from *Trans. Amer. Orthopedic Asso.*, Sept., 1891.

St. Louis, Mo., has presented us with the second number of a new medical journal, the *Medical Fortnightly*, conducted by Dr. Bransford Lewis, assisted by Dr. Frank C. Hoyt, associate editor, and by a large corps of collaborators. The number received is very satisfactory. We wish it all success.

*Stricture of Rectum.* A Study of One Hundred and Thirty-eight Cases. Second edition; enlarged. Chas. B. Kelsey, M. D., New York, Professor of Diseases of Rectum, N. Y. Post-Graduate School and Hospital.

*Clinical Lecture.* Tenotomy by Open Incision; Torticollis, Subcutaneous Tenotomy, etc. By H. AUGUSTUS WILSON, M. D. Reprinted from *American Lancet*, February, 1892.

*The Practitioner's Monthly.* A journal of practical medicine, Vol. 1, No. 1, March, 1892. Edited by C. L. Dodge, M. D., and J. CHAMBERS, M. D., Kingston, N. Y.

*Publications Received.* Reports from the Consuls of the United States, No. 136. January, 1892. Washington, D. C., Government Printing Office.

*Biography of Eminent American Physicians and Surgeons.* Illustrated with fine photo-engraved portraits. Edited by R. FRENCH STONE, M. D., 16 W. Ohio St., Indianapolis, Indiana. The design of this publication, soon to be issued, as stated by the editor, is to present short biographies of the active progressive men in the medical profession whose work entitles them to consideration. The book is to be sold by subscription only, and will be completed about the end of 1892. The advance sheets sent us are neatly gotten up, both type and photographs being good. There is certainly need of a book of reference in which one may find something concerning the life and work of prominent medical men; especially when their photographs attend the description; and we wish Dr. Stone success in his effort.

### Medical Progress.

#### THE CONSTANT ELECTRIC CURRENT IN INTESTINAL OCCLUSION.

Dr. Seminola contributes to the *British Medical Journal*, Feb. 20, 1892, the following suggestive article:

The clinical case which forms the subject of this note is very important, and perhaps unique, in medical literature, as demonstrating clearly (1) that there may be an intestinal occlusion due exclusively to transient intestinal paralysis through defective innervation; (2) that the constant electrical current has a truly marvellous effect in these cases.

The patient (C. S., of Secondigliano) was a young man aged 20, of sound constitution, of normal osseous development, and in good general health, with the exception of a nervous temperament. He fell ill with severe stercoraceous colic,

of which he was cured by ordinary treatment. After the colic he suffered from typhlitis and perityphlitis, but was completely cured by antiphlogistic treatment and milk diet. During convalescence he was attacked one day with diarrhœa in consequence of some trivial error in diet. The day after the cessation of the diarrhœa he was attacked with most acute pain, with constipation, persistent vomiting, scantiness of urine, etc. The attacks of pain succeeded each other with great intensity every twenty to thirty minutes, and during these colicky attacks the intestinal coils were clearly visible all over the abdomen. The physicians in attendance instituted very active treatment—hypodermic injections of morphine, ice to the belly, hot hip-baths, poultices, calomel in large doses, etc. All these measures proved futile; the bowels remained locked; the pains continued very severe; the vomiting was obstinate and refractory to treatment, while the scanty secretion of urine was followed on the second day by complete retention, so that the catheter had to be employed two or three times a day. One of the doctors in attendance insisted on using enemata of olive oil, and first two and then three litres were thrown into the bowel. Nevertheless the condition of the patient became worse.

I was called into consultation on the third day, when taking into account, first, the sudden onset of the pain, secondly, the paroxysmal character of the pain, and the freedom from suffering between the attacks when the abdomen was soft and pressure did not cause any pain; thirdly, the mapping out of the intestinal coils at different points during every attack of pain; fourthly, the intestinal occlusion which had come on suddenly after the patient had been repeatedly purged, and on the day following an attack of acute diarrhœa; fifthly, the existence of paralysis of the bladder, which had come on without any apparent cause so far as the genito-urinary apparatus was concerned, and which has never been recorded as a concomitant of ordinary intestinal occlusion; sixthly, the neurotic temperament of the patient—I distinctly expressed the opinion that the intestinal occlusion was due to the nervous paralysis, and I urgently recommended the immediate application of the constant electric current. This advice was at once endorsed by the excellent practitioner in attendance, Dr. D'Auria, but the other medical men maintained that this measure was useless, and that it was necessary to perform laparotomy without delay. Dr. Vizioli, Professor of Electro-Therapeutics in the University of Naples, was called in. The constant current which was employed was furnished by a Daniell's battery with Onimus's piles, modified as regards the graduation and the number of piles, by Professor Vizioli. The intensity was measured by a milliampère galvanometer, the strength employed being 10 milliampères at every application. The positive pole was, by means of a rectal catheter, carried 20 to 25 centimetres up the bowel; and the negative pole, which was olivary in form and covered with cloth steeped in a saturated solution of chloride of sodium, was rubbed transversely over the surface of the abdomen, especially in the parts corresponding to the cæcum, the ascending, transverse, and descending colon, and the sigmoid flexure, as well as over the hypogastric region. The duration of each application was from eight to ten minutes, and there were three sittings every day. By the end of the first day the retention ceased, the patient was able to pass water freely, his general condition improved, especially subjectively, and the attacks of pain were less violent, but the bowels were still constipated.

The surprising result of the treatment shown in the cure of the retention confirmed me in my own opinion of the nature of the case; and notwithstanding pressure constantly brought to bear in the opposite sense by the other doctors,

who terrified the family with pictures of imaginary dangers because they were determined at all hazards to have laparotomy performed, the electrical applications were continued, and, after the ninth sitting, the patient had spontaneous motions of the bowels, and by degrees he completely recovered.

#### THE INFLUENCE OF FORESTS ON CLIMATE.

Discussing the "variations of climate" in the *Popular Science Monthly*, April, 1892, Mr. Larrabee says in regard to the abundance of forest growth:

The presence of forests has not been shown to contribute directly to the increase of rainfall, nor their removal to diminish it. Yet their influence on climate must be considerable. This is confessed when the farmer on the prairies plants belts of trees between his fields and the quarters from which cold winds and destructive storms are expected. They stand like a wall to protect the localities they overhang against the sudden extremes of temperature and the other accidents of violent weather. Although they may not increase the amount of precipitation to a perceptible extent, they, by means of their matted roots and the undergrowth which they promote, and by their beneficent shade, convert the ground on which they stand into a kind of reservoir, and husband the moisture which, without them, would run off or dry up at once. Thus they contribute to prevent sudden floods in the wet season, and, permitting a slow exudation of moisture into the streams, to keep them lively and the rivers to which they are tributary full during the dry seasons. Many persons believe, too, that they diffuse a coolness and vaporous moisture in the atmosphere, the presence and influence of which, although they are not manifested in rain, are nevertheless real. Whether they may not exert an influence on the distribution of rain through the seasons, as they certainly do on that of ground moisture, does not appear to have been yet adequately investigated.

#### THE FRENCH LAW TO PROTECT INFANTS.

In the *Lancet*, March 12, 1892, a correspondent comments thus on the efforts made by the authorities of Paris to prevent loss of infant life:

Patriotic law-makers are very sensitive on the question of the decline of the population and the eventual relegating of France to a, numerically speaking, second- or third-rate position amongst the family of nations. Remedy after remedy has been suggested to stem this decline, but while it is generally felt that the control of human production is beyond the ken of Acts of Parliament, the Code Napoleon can at least be made to serve a purpose in safeguarding the existence of the newly acquired additions to our population. A year ago the Prefect of the Department of Orne enjoined the local practitioners charged with the inspection of the numerous infants which are nursed at the expense of the Assistance Publique, to refuse to give the necessary certificate to any nurse who used in the rearing of her charge a bottle with a tube, or who gave the child any form of solid food before it reached the age of one year, unless otherwise ordered by the practitioner. It was one thing, however, to thus threaten the nurses, but it was quite another matter to get them to carry out the order. In their annual report the medical inspectors pointed out to the Prefect the impossibility of getting strict compliance with his order short of a formal local Act or by-law. This has now been enacted, and in the following terms:—It is prohibited (1) to give to infants under one year any form of solid food unless such be ordered by a written prescription signed by a legally qualified medical man; (2) it is further prohibited for the nurses to use, in the rearing of infants confided to their care, at any time or under any pretext whatsoever, a bottle or bottles with tubes. Then fol-

low the penalties which will overtake nurses who do not conform to the above. In the reforms in the law which cannot be long delayed on your side of the Channel on the burning question of infant life assurance and its terrible abuses, note might with advantage be taken of the foregoing life-saving enactment.

#### THE BACTERIA OF CHEESE.

In an article upon "bacteria in our dairy products" (*Popular Science Monthly*, April, 1892), Professor Conn writes:

If bacteria are an aid to the butter-maker, they are absolutely indispensable to the cheese manufacturer. Some people do enjoy the taste of sweet-cream butter, and there has been for some time an evident tendency toward a desire for less strongly tasting butter. But no one desires to eat fresh cheese. When first made, cheese is soft and tastes somewhat like milk curd. It has none of the palatable taste which we find in the cheese of our table. It is a long ripening which gives this taste to the cheese.

Here, again, the ripening process is one of bacteria growth. The millions of bacteria that were in the milk are stored away in the cheese, and instead of being killed here, as they are in the butter, they begin to multiply immediately. Here, too, there is a battle of bacteria, and now one species is in the ascendancy and now another. If the wrong species gets the upper hand, the cheese becomes bad, and cheese-makers have their greatest trouble from this source. The bacteria do not grow so rapidly as they do in cream, for the conditions are less favorable, but the ripening is kept up for months, and during the whole time the bacteria are growing. Under their action the character of the cheese slowly changes. Here, again, the decomposition products are responsible for the taste and odor. In some cases, such as Limburger cheese, the action is allowed to continue to the verge of putrefaction. Ordinarily it is not continued so far, but in all cases the cheese-maker favors the growth of certain forms of bacteria by regulating the temperature at which the ripening is carried on. As the ripening continues, certain parts of the cheese are digested and decomposed by the bacteria growth, and, as the products of decomposition accumulate, the taste grows stronger. After a time it is considered fit for the market, but the longer the ripening continues the stronger the taste becomes.

Little is known yet as to the bacteriology of different kinds of cheeses. Whether the different tastes of Edam, Limburger, and other characteristic cheeses is largely due to the character of the bacteria ripening them can not be said. Cheese-makers do, however, have much trouble with various irregular forms of ripening, and a great drawback in this business is the lack of uniformity in this respect. Beyond doubt this is due largely, perhaps chiefly, to the variety and number of bacteria which succeed in gaining a foothold in the cheese and contribute to its ripening.

Along the line of cheese manufacture our bacteriologists are promising us help from their researches. Of course, the cheese-maker has never paid any attention to the sort of bacteria which he plants in his cheeses, for he has never heard of them. Sometimes he has unwittingly planted species which produces violent poisons, as is shown by the many instances of death from eating poisonous cheese. Now, our bacteriologists are suggesting that the ripening of cheese may be easily controlled. Artificial cultures of the proper sort may be furnished the cheese-maker, and if these are planted in the cheese not only will the danger from poisonous cheese be prevented, but at the same time the desired taste of the cheese be assured.



## INTER-PARTUM HOUR-GLASS CONTRACTION IN A CASE OF TWINS.

On January 31st I was called to Mrs. E., and found her in labor with twins. Having used forceps in her last confinement, eleven months previously, without any unnecessary delay I delivered the first fœtus in the same way, and within a quarter of an hour one of the placentæ was expelled naturally. Upon examination to ascertain the position of the second fœtus, I saw an arm presenting; and on introducing a hand for the purpose of turning, I found the upper arm so firmly and tenaciously gripped at the internal os uteri as to render it impossible to pass a finger-tip beyond the contraction into the upper segment of the uterus. In the interests of the fœtus, which was then alive, I administered two 20-grain doses of hydrate of chloral with only very partial success in relaxing the obstruction—just enough to allow the funis to descend partially and become compressed. I was able to return the cord in a pulsating condition, and tried the effect of steady continuous pressure with the two fingers which I managed to pass through the constriction. This being of no avail, I placed my patient deeply under the influence of chloroform, with no better effect; and as I found the funis had again prolapsed through the constriction, and was now non-pulsatile, and there being no urgent reason on the part of the mother for further interference, I left matters to nature. In about an hour or so, uterine action having recommenced, and the spasm having given way, I re-chloroformed the patient, and easily turned and delivered.

The chief points of interest in this case are (1) the rarity, according to the best authorities, of hour-glass contraction; (2) the presumable extreme rarity of *inter-partum* hour-glass contraction; (3) the fact that a well-marked sulcus presented itself on the upper arm at the point of constriction, whilst the inferior part of the arm was swollen and cyanosed, this leaving outward and visible signs of the tenacity and persistency of this rare form of hour-glass contraction.—Dr. Eames, in *Brit. Med. Jour.*

## ETHER AS A STIMULANT AT THE TEMPERANCE HOSPITAL.

A correspondent of a contemporary expresses surprise that at a public meeting at the Temperance Hospital it was announced that the internal use of ether is allowed in the hospital in place of alcohol. We can not think that there is much to justify this difference. Ether drinking is a vice which has but lately in Ireland assumed grave proportions, requiring special legislation. It is affectation to regard the use of such an agent as morally or physically better than the use of approved forms of alcohol. By all means let the physicians of the Temperance Hospital cure disease—where they can do so equally well and equally quickly—without alcohol. Such treatment is instructive, but where some form of diffusible stimulant is needed, to prefer ether to alcohol is scarcely the way to promote temperance.—*Lancet.*

## THE CAUSATION AND TREATMENT OF PILES.

At an ordinary meeting of the London Medical Society on March 7, Dr. Lauder Brunton read a paper on the Causation and Treatment of Piles and Allied Affections. After pointing out that dilatation of the hæmorrhoidal veins might be due to obstruction to the return of blood, either in the liver or at the point where the hæmorrhoidal veins pass through the muscular coats of the rectum, he referred to the various conditions under which the different kinds of obstruction might occur. Over-eating led to congestion by maintaining the liver cells in a state of repletion, thereby interfering with the local circulation. Cold might act either through the liver or by causing reflex contraction of the muscular walls of the rectum, and so preventing the blood finding its way back through the veins. In

reference to the influence of cold in causing disturbances of the alimentary canal he pointed out that the parts of the body most susceptible to chill were—(1) the nape of the neck; (2) the abdomen; (3) the shins; and (4) the feet. Passing to the question of treatment, the author, after alluding to the beneficial effect of mercurial purgatives followed by mild salines in the prevention of hepatic congestion, showed that though large doses of aloes might conduce to the formation of piles by unduly stimulating the muscular coats of the rectum, small doses exerted a contrary effect. Another way of relieving such hepatic congestion was to apply hot-water bags to the back of the neck and over the liver. When a patient was subject to piles it was advisable that he should accustom himself to empty his bowels at night, in order to secure rest in the recumbent posture after defecation. Moreover, when there was much irritability it was preferable to use a soft sponge and water, instead of paper mool or less harsh. He also advised the introduction of a pledget of animal wool dipped in hamamelis, which acted as a mechanical support and a local astringent. With regard to this he observed that the official extracts or tinctures were not so efficacious as certain proprietary preparations. In obstinate cases he had obtained great relief from the use of the anal pad.

In the discussion following, Dr. Cripps said that the pathology and treatment of external and internal piles were essentially different. External piles, in the majority of instances, owed their origin to some crack or fissure of the anus, due to cold or dryness, mere "chapping," in fact, leading to a little local inflammation and œdema of the folds of skin. This condition required nothing but the most simple treatment, and had nothing to do with congestion of the liver. Indeed, he had utterly failed in a series of experiments in the deadhouse to inject the anal plexus of veins through the portal veins. Sometimes, however, there was rupture and consequent thrombus of one of the small veins in this neighborhood, resulting in some local inflammation, which cleared up in a day or two with or without treatment. Internal piles, on the other hand, were liable to become inflamed and strangulated, leading to hæmorrhage and prolapse of the rectal mucous membrane, and called for active surgical treatment. He agreed that newspapers for cleansing purposes was to be deprecated, but he did not think that a sponge would improve matters. Dr. Lazarus Barlow did not believe that the liver had anything to do with either internal or external piles in most cases. In lardaceous disease and cancer of the liver there was no particular tendency to piles. Liver congestion was never better marked than in persons suffering from diseases of the mitral valves—a lesion most marked in young people, who were notoriously little liable to suffer from piles.—Dr. Campbell Pope mentioned a case in which an attack of piles followed sitting down on wet hay. Cold and wet operated in this direction, but he was of opinion that sexual excitement was perhaps the most potent and common factor.—Mr. Goodsall insisted upon the heredity of the tendency to pile formation, and upon the effect of strains, efforts, cough and pregnancy in the same direction.—Mr. Pearce Gould urged that some reform in the nomenclature of the subject was desirable, seeing that the term "pile" covered a multitude of totally different conditions. Benefit attended the relief of constipation by the habitual use of enemata instead of purgatives.—Mr. Boyce Barrow declined to admit that the pathology of external piles was essentially different from the internal. The straining assigned as a cause of the latter he believed to be a consequence rather than a cause, though it might exaggerate pre-existing piles. An operation that cured the piles might also cure the billiousness. He did not believe that local treatment was of any value.—Dr. Brunton, in reply,

pointed out that in his paper he only mentioned congestion of the portal circulation as one of the possible causes and not as *the* cause. He could not accept Dr. Cripps's dictum as to the absence of anastomoses between the hæmorrhoidal veins and the oval plexus, and he did not see how any accumulation of fæces could press upon the veins higher up so as to cause stasis.

#### THE FUNCTION OF THE HAIR-TUFTS IN MAN.

A recent writer formulates a theory to account for the persistence in man of the tufts of hair usually present in the axillæ and over the pubes. These he imagines to be the persistent remnants of hair-tuft developed with reference to the clinging or grasping power of the young, and as a means of enabling them to cling to the parent when he or she, as the case might be, was not in a position to spare an arm without much imperiling the chances of escape or rendering movement difficult. Naturalists have observed that young apes hang beneath the body of the mother and sustain themselves by grasping the hair, and it is stated that certain male gibbons assist in carrying the helpless young. It is an interesting point that in these apes the period of immaturity is prolonged almost as much as in man. Other considerations which he looks upon as supporting his theory are the appearance of the hair at puberty, its appearance in both sexes, and the fact that it often appears earlier and more plentifully on the female. It also exists in parts where the young of tree-climbing animals could attach their hands without danger of violent contact from obstacles, and he has ascertained by measurement that in most cases the situation of the axillary and pubic tufts is within easy reach of the hands and feet of infants when their limbs are extended, if the body of the adult is in the position taken by that of an anthropoid ape in climbing.

The author of this theory must want "awfully" to believe that man is but an evolved ape. We wonder if such ancestral ape-men were ever idiotic.

#### INFECTIVE INFLAMMATION OF THE VESICULÆ SEMINALES.

An excellent article upon this subject is published by Dr. Primrose in the *Canadian Practitioner*, March 1, 1892. We can quote but a few sentences:

In gonorrhœal epididymitis, it is probable that the inflammation travels from the urethra along the ejaculatory ducts and vas deferens. When we consider the path it takes, the long course from the prostatic urethra to the epididymis, we must necessarily expect that the other structures nearer at hand and in more intimate relation to the prostatic urethra would take part in the inflammatory process. We would therefore expect to find the prostate or the vesiculæ seminales frequently implicated, and, in fact, more frequently the seat of secondary infection than the epididymis. As a matter of fact, the frequent occurrence of prostatitis is said to be perhaps the commonest complication of gonorrhœa; the ducts of the prostate gland open into the prostatic sinus in the floor of the prostatic urethra, and no doubt along these ducts the inflammation may travel. It would, indeed, be curious if the ducts proper to the prostate should be selected by the inflammatory process and the ejaculatory ducts escape.

It is worthy to note that the symptoms of acute inflammation of the prostate would present characteristics very similar to those presented by inflammation of the vesiculæ seminales.

It would therefore be difficult to diagnose between the two conditions, and it is probably on this account that inflammation of the vesiculæ seminales is seldom, if ever, recognized.

Inflammation of these structures at the neck of the bladder is often very per-

sistent; the pain is intense, and is greatly exaggerated after the act of micturition. When this condition is unduly persistent, and all ordinary remedies fail to give relief, the patient continuing to suffer for weeks, or even months, we may suspect that the trouble is located in the vesiculæ seminales and not in the prostate. We must not come to this conclusion on these grounds alone, but an examination per rectum may aid us, and we may be able to detect the position of an inflamed vesicula seminalis, which we will find indurated and very tender, occupying a position extending beyond the base of the prostate. The inflammatory process in the vesiculæ seminales follows a similar course to that occurring in the epididymis, an organ of a like anatomical structure, namely, a convoluted tube. We are familiar with the character of the inflammatory process in the epididymis. At first, very acute with intense pain, and probably very high fever; after the acute stage has passed off, a subacute stage supervenes, in which there is still a considerable amount of tenderness and the organ remains indurated; the induration and pain may persist for some months; suppuration may occur, and is by no means infrequent. We find the statement made that inflammation of the prostate may lead to suppuration and the formation of an abscess. It is quite possible, however, that many of the abscesses which are supposed to originate in the prostate are really in the vesiculæ seminales.

The symptoms and signs of inflammation of the vesicles are similar to those usually ascribed to the acutely inflamed prostate; the condition usually develops in the third or fourth week of the gonorrhœal attack; pain deep in the pelvis and perineum and toward the end of the penis; frequency of micturition and urgency, with a severe exacerbation of the pain on completion of the act of micturition; the urine first passed is of normal appearance, but toward the end of the act of micturition there is a muco-purulent discharge with blood occasionally. An examination per rectum, however, yields the most characteristic signs. The swelling occupies the whole of the base of the bladder from side to side, and extends beyond the reach of the finger. One can not conceive it possible that the prostate, shut up as it is in its own fibrous capsule, can swell to this size in the course of a few hours.

It is the peri-vesicular connective tissue which is the chief seat of the inflammatory process, resembling in this particular a similar condition in the epididymis. The usual termination is that of resolution, but suppuration may supervene. The abscess formed may open in the perineum, or into the rectum, bladder, or urethra, and it is stated that Douglas' pouch may be opened up and the pus discharged into the peritoneal cavity.

The treatment of the condition may be considered from two points of view: (1) preventive; (2) palliative and curative. The administration of diluent drinks and diuretics during the acute stage of gonorrhœa does much to prevent passage of the inflammation backwards along the urethral canal. A flushing-out process is thus carried on, and the poison is by this means, to a certain extent, got rid of. On the other hand, urethral injections during the early stage of a gonorrhœa are to be condemned; they may, it is true, do good, but a great danger exists of carrying the virus backward, setting up infective inflammation near the neck of the bladder. When inflammation of the vesiculæ seminales has been established, then our flushing-out process will have little effect upon it; nevertheless we must not even then employ urethral injections, for fear of carrying the inflammation still further back in the prostatic urethra to the bladder, with the danger of setting up a gonorrhœal cystitis. The passage of instruments must be avoided if possible, as the same danger is encountered there. We can do much to

allay suffering by ordering a hot hip bath. Occasionally the injection of cold water into the rectum is grateful to the patient. The better way of relieving pain and diminishing frequency, however, is by administering belladonna in the form of suppositories. The bowels must be kept active by saline cathartics. The patient should be kept on a milk diet and stimulants prohibited. These are the chief indications in treatment. When the acute stage has subsided, tonics of iron, strychnine, or quinine are serviceable. Quinine seems to be of use also in diminishing frequency, although its specific action here is not generally recognized. If any abscess forms it must be opened early because of the danger, if tension be not relieved, of the pus burrowing in dangerous localities.

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### Medical Items.

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A death from paraldehyde is reported in the *Nashville Journal of Medicine and Surgery*. A girl of twenty by mistake took six or seven drachms of the drug, became unconscious in a few minutes and died in a few hours.

A death from hydrophobia occurred recently in England. The victim was a boy of nine years who had been bitten by a rabid dog. He was sent to the Pasteur Institute in Paris and discharged as cured, but the disease developed in a few months and he died despite active treatment.

It is said that in Paris alone 145 medical journals are published, in addition to 8 pharmaceutical, while lay publications of all kinds number only 161. The medical profession seems to be provided with its full share of literary pabulum.

We learn from the *Illustrated Buffalo Express* that work has been begun on a handsome and spacious new building for the School of Medicine, almost as large as that of the corresponding school in Columbia College. The Buffalo Medical College has for many years stood high among our American schools, and we are glad to note this evidence of prosperity.—*N. Y. Med. Jour.*

Dr. Feilchenfeld has employed in chronic constipation of women after childbirth, in hæmorrhoids, and in heart and kidney affections, the plan of placing upon the abdomen a shot-bag weighing three or four pounds, and leaving it often over night, if necessary, but usually finds that after an hour's time a regular passage is secured.

The annual appointment of a resident physician for the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore City will be made on the first of April, 1892. Applicants desirous of obtaining the valuable experience derived from the clinic work in this hospital will send their applications to Dr. J. J. Chisolm, 1007 E. Baltimore St., Baltimore, Md.

Goodhart, in the *American Journal of Medical Sciences*, says that to order dialyzed iron for cases of chlorosis is to play with the remedy and to waste time. The saccharated carbonate of iron, or reduced iron, in half drachm doses or more, three times a day, for at least six weeks, will cure such cases.

In the House of Commons, of London, on March 22, the Right Hon. Sir James Ferguson, Postmaster General, in opposing the bill for the establishment of a new telephone company, announced that the government would promote a measure placing the telephone trunk lines in the hands of the postoffice depart-

ment, which would use the present telephone systems in alliance with the trunk lines.

In London a physician receives a half-crown fee for each case of notification of contagious disease. In Connecticut also there is, or used to be, a fee of twenty-five cents for each notification of contagious disease and each birth certificate. If the New York authorities were equally just in their recognition of the doctor's right to be paid for his services, there would doubtless be no need for the threats of prosecution by the health authorities, which are so often used to force physicians to obey the law in this respect.—*Medical Record*.

The Committee appointed at the last meeting of the American Medical Association to consider the best means for promoting the prosperity of the sections of the Associations will hold an adjourned meeting in the Hotel Cadillæ, Detroit, Mich., June 6, 3 P. M. Members of committee are requested to notify the chairman of their intention to be present at this meeting. The committee would esteem it a favor if each member of the Association would communicate in writing his or her views concerning the best measures for promoting the development of the sections. Such communications may be sent to the chairman of the committee, J. D. Marshall, M. D., Chairman, 9 Jackson St., Chicago.

There are no class of practitioners better able to report interesting cases and experiences than the country doctor. Isolated as they so frequently are, miles from consultation or assistance, where all classes of work come under their observation and treatment, they are necessarily self-reliant, depending as they have to do on their own wit and shrewdness for diagnosis and treatment, and their ingenuity to improvise and supply the place of apparatuses that may be necessary in special cases. And it is a very rare occurrence when they are not able to meet successfully all emergencies. There is only one thing that these men are laggards about, only one complaint that we make against them, and it is they will not write out and report their cases. Whenever you meet them, they tell you of any number of interesting cases and experiences; even promise to write them out for you, but that is the last ever heard of the case.—*Gaillard's Med. Monthly*.

Foreign diplomas were barred out by the Illinois State Board of Health for the following reasons: 1. The diplomas of medical schools and universities do not entitle the holders to practice in these countries. 2. The Prussian Staats Examen Commission rejected in 1890 more than forty per cent. of the graduates of the University of Berlin, more than forty-seven per cent. of the Breslau graduates, more than thirty-one per cent. of the Griefswald and Halle graduates—and, in fact, more than twenty-nine per cent. of the university graduates that came before the commission. 3. Many of the rejected candidates come to this country. 4. Many such graduates, fearful of failing in the government examinations in their own countries, come to this country to enjoy a privilege denied them at home of practicing medicine simply on their diplomas. 5. The Illinois State Board of Health feels that it should not place upon such diplomas a higher valuation than is given them in the countries in which they are granted.—*Western Medical Reporter*.

Any one sending the following numbers of the JOURNAL: Vol. XXIV, 1890-91, Nos. 1, 9, 12; Vol. XXVI, 1891-92, No. 1, will be paid ten cents for same.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.

# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

- Chronic Endometritis. By J. M. Baldy, M. D.,  
of Philadelphia. . . . . 485  
Malformations of the Rectum and Anus. By  
J. Fussell Martenet, M. D., of Baltimore. . . . . 488

### SOCIETY REPORTS.

- Clinical Society of Maryland. Stated Meeting  
held Feb. 19, 1892. Treatment of Granular Con-  
junctivitis. Phlegmasia Alba Dolens. . . . . 494

### EDITORIAL.

- Medical Appointments. . . . . 499

- The Problems of "Practical Politics." . . . . 500

### MEDICAL PROGRESS.

- A Case of Laryngeal Vertigo or Laryngeal Epi-  
lepsy.—Is Our Health Department to Continue  
an Asylum for Political Bummers?—Manifes-  
tations of "La Grippe" in Children.—Artificial  
Maternities.—Arkansas Has It.—Local Abstrac-  
tion of Blood in Sciatic Neuritis.—Stomatitis  
Materna.—Relations Between Chorea and Epi-  
lepsy. . . . . 501

- MEDICAL ITEMS. . . . . 506

## Original Articles.

### CHRONIC ENDOMETRITIS.\*

BY J. M. BALDY, M. D.,

Professor of Gynæcology in the Philadelphia Polyclinic; Surgeon to Gynæcean  
Hospital; Gynæcologist to St. Agnes's Hospital.

Of late years it has become the habit of gynæcologists to consider almost all en-  
dometrial disease as symptomatic, and not an independent lesion. It is certainly  
true that many pelvic diseases are accompanied by an unhealthy condition of the  
endometrium; especially in pelvic inflammatory disorders the lining membrane of  
the uterus is so frequently affected as to have given rise to the supposition that it  
is either caused by the pelvic disease, or rarely occurs independent of it. In fact,  
such assertions are frequently made in print and on the floors of our societies.  
The temptation is strong to accept this theory, which appears at first blush to be  
so plausible, but which is nevertheless most fallacious. My daily experience is  
teaching me that endometritis as an independent disease is a common disorder,  
and is at the bottom of many of the discomforts suffered by women. The causes  
giving rise to this disease are much the same as those which originate vaginitis,  
and particularly salpingitis—specific infection and post-puerperal sepsis being  
the most prolific, and giving rise to the bulk of the cases. Oftentimes the begin-  
ning of the trouble can easily be traced to child-birth or to an abortion. The

\*Read before the Philadelphia County Medical Society, February 10, 1892.

woman has had a slow get up, and will give the history of some fever, or she has regained her usual health very slowly, and possibly not at all; she will have complained of a vaginal discharge since her confinement, when previously she had been free from this annoyance. The history may be that of an attack of specific infection. Sometimes the history in such a case is clear—a sudden appearance of a yellowish vaginal discharge, with swelling of the labia and burning micturition. At other times the evidence of specific infection is not entirely satisfactory, but it is quite notorious that women often become contaminated without giving it any particular attention, or the discomfort has been so slight as to be soon forgotten. In any event, if the disease be neglected and spreads to the cavity of the uterus, it soon spends its force and settles down to a chronic condition. It may or may not extend into the Fallopian tubes and cause a salpingitis and peritonitis. Should it do so, as is often the case, the removal of the appendages will not necessarily bring about a cure of the patient. In fact, this is the secret of the failure of laparotomy in many of the cases which are going from one clinic to another for relief. Even if the disease is complicated by pelvic disorders of an inflammatory nature, especially if the two arise from the same cause, it is well to first turn our attention to the endometritis, in which case a laparotomy may at times be avoided. In other words, in certain cases, embracing the two diseases, the symptoms from the endometritis may overshadow those from the salpingitis; this is especially true of many instances in which the intra-peritoneal damage has not been very serious. In those cases where the intra-peritoneal inflammation has subsided, and only its products remain, the treatment of the endometrial inflammation, which, under these circumstances, is usually chronic, can be carried out with impunity if ordinary care be taken. Of course, in the event of there being an acute or even a subacute pelvic inflammatory condition present, great care must be taken not to interfere with the uterus in any way, else an already bad condition of affairs may be made much worse, and even serious. In many patients, in whom there exists post-*puerperal* septic endometritis or specific endometritis, the disease has stopped short of the tubes, and has not involved either them or the peritoneum. These cases are quite common, and are daily overlooked. The women wander from one doctor's office to another, and finally, when their money is all gone, into the public clinics, seeking relief in vain. It is often a matter of surprise to me that many of them have never even had an examination made, but have been treated for months and years with drugs, or have been advised to use an injection of hot water. The hot water injections as usually given are worse than useless. Just sufficient water at a moderate temperature is used to cause a congestion of the uterus and pelvis, which congestion is not relieved by the secondary effect of the hot water, *viz.*: the contraction and consequent driving away of the blood from the parts. These women suffer from a continual uterine discharge more or less profuse; there is, perchance, a feeling of weight and heaviness in the pelvis, accompanied by backache; sometimes they feel weak and worn out. Menstrual function is disordered, being generally irregular and profuse; pain may or may not attend this function. These symptoms exist either alone or in various combinations, the only constant and reliable one being the uterine discharge. A local examination discloses an enlarged and heavy uterus, from the cervical canal of which an unhealthy thickish discharge is oozing. Oftentimes the cervix is eroded, and the mucous membrane of the everted lips, if the lips be everted, bleeds on being touched with a piece of cotton or an instrument. This hæmorrhagic condition is more apt to be present when the disease is still acute or subacute; but, nevertheless, it is at times seen in the



chronic cases. In some instances the uterine body is comparatively normal to the touch so far as its consistency is concerned; again, it may be either too soft, or, what is more common, extremely hard, and even almost fibrous in character. These changes indicate that the disease is not altogether confined to the endometrium, but has invaded the structures comprising the uterine wall. It is no uncommon thing to see an endometritis and metritis coexisting; in fact, in chronic cases it is rather the rule than the exception. The disease is almost always primarily an endometritis, and treatment which will cure this affection will be followed by a cure of the metritis almost as a matter of course. So much is this the rule that I have gotten to look on these two diseases as very much one and the same.

Where this condition of affairs exists—a large and abnormally heavy uterus—there is very apt to be a retro-displacement of the womb sooner or later. Whether or not all displacements which give rise to trouble are originally caused by uterine inflammations, it is a curious fact that it is a very rare thing to find a troublesome retro-displacement without either uterine or pelvic inflammatory diseases complicating it.

For the treatment of uncomplicated endometritis and metritis there are a variety of remedies, some of them quite effective, while many of them are useless, and are applied in a haphazard way. My own preference is to adopt the shortest and surest course of procedure. The woman is put under ether, the cervix is dilated, and the uterus thoroughly curetted; the uterine cavity is then washed out, and an application of Churchill's iodine made to its surface. If there is pretty free bleeding in consequence of these manipulations, the uterus is packed full of iodoform gauze, which is removed in the course of a day or two, as circumstances demand. Ergot may or may not be given by the mouth, the indications for its use being hæmorrhage or an enlarged heavy uterus. Usually, I give a half drachm of the fluid extract, three times a day for a short period, gradually reducing the quantity until it is dispensed with altogether within about a week.

As to the steps of the operation: The patient is placed in the dorsal position, the dilatation is made with the Goodell rapid dilators after careful antiseptic precautions. I dilate usually only sufficient to introduce and manipulate my instruments easily—from three-quarters of an inch to an inch. Great care is taken to make the curettement a thorough one. All debris can be washed away, and the cavity cleansed by the use of the rectal nozzle of a Davidson syringe. The application of iodine follows immediately, it being applied with a long-nozzled uterine syringe. The patient is now returned to bed, and nothing more is done for a week or two, excepting to give absolute rest, hot water injections, and keep the bowels soluble, together with the ergot as indicated. I have not found the occasion to place a hard rubber drain in the uterus, as Wylie does, nor to pack it with iodoform gauze for a prolonged period, as Polk proposes. I find, if my dilatation has been properly made, that the cervical canal remains sufficiently patulous for the necessary drainage. The uterus will in one way or another resent the presence of a foreign body, and these procedures can only result in just so much more irritation and consequent discharge.

Some patients are cured altogether by this treatment; but, for the most part, in order to secure a thoroughly satisfactory result, treatment must be kept up for some little time after the woman is allowed to get out of bed. It is my habit, in these cases, to make an intra-uterine application of iodine about twice a week for a few weeks, then once a week, and finally to withdraw the treatment altogether; the hot water injection should be kept up twice a day throughout the whole

course of treatment. It is not uncommon, where the endometrium has undergone a fungoid change, for the disease to return, and the whole treatment has thus to be gone through with a second time.

Many patients will not submit to this treatment, in which event it becomes necessary to resort to other methods of management. A prolonged course of intra-uterine treatment will, in many cases, eventually bring about the same result. I do not maintain that iodine is the only remedy to be used for this purpose, but I have come to use it routinely for the reason that I have found no other drug which would give better results. It is not advisable always to use it in full strength, in which case it may with advantage be diluted with glycerine in the required proportions. Ichthyol and all similar substitutes have only proven disappointing.

So much for the uncomplicated cases of endometritis. Where the disease is accompanied by a pelvic inflammatory condition, the first question to settle is whether or not an abdominal section is to be performed for the removal of the appendages. If they are not sufficiently affected to call for the operation, and if the uterine symptoms predominate, and are very annoying, I have no hesitation in treating the uterine cavity. A long-nozzled uterine syringe may with safety be passed into the uterus, even in the presence of considerable pelvic disease, and a local application thus made. In these cases the strength of the material injected should be regulated by the amount of inflammation, as a strongly irritating fluid will be much more likely to cause trouble than the mere passage of the instrument itself. When the pelvic disease has been an old one, quiescent, I have not hesitated in gently dilating the cervix and curetting the cavity of the uterus, nor have I ever had any trouble follow such a procedure. In this class of patients there is an opportunity for the nicest kind of judgment, and if one be skillful and careful in selecting the proper cases the treatment may be followed by the greatest benefit. I am perfectly well aware that this is contrary to the teachings of many gynæcologists of the present day, but my experience in these matters has opened my eyes to the fallacy of such ideas. If the gentlemen opposing the practice of intra-uterine treatment would try it on some of their cases who continue to have enlarged uteri and a vaginal discharge after the removal of the appendages, they would soon become convinced of its practical value, even in these cases.

The treatment of endometritis by electricity I have not touched upon, not that I do not approve of it, but because Dr. Massey follows me with a paper on that subject. It is especially valuable in those cases which refuse the above line of treatment.

### MALFORMATIONS OF THE RECTUM AND ANUS.†

BY J. FUSSELL MARTENET, M. D., BALTIMORE.

Clinical Assistant Department of Children, Johns Hopkins Hospital Dispensary.

The subject matter of this paper is one not of special interest, and one from which very little discussion can be elicited; as the occurrence is one simply of imperfect or interrupted development, without any special pathological meaning or interest; yet it is a condition which is so seldom met with that I appreciate the need of some familiarity with it on our part; and one in which the questions will be asked "With what form or degree of malformation have we to contend? What operative measures are at our disposal? Have or have they not offered satisfactory results? And should they be or not be undertaken?" In any special case under

†Read at the 733rd regular meeting of the Medical and Surgical Society of Baltimore, Dec. 24, 1891.

consideration, you should be able to discuss it with and offer reasons to the family for your action. The definition is simple, being purely a defective development, and dates its origin to an early fœtal period. There are a fairly large number of these cases of the several varieties on record, and I have made no effort to search the literature, so as to give any definite statement of the number. The occurrence, however, is not frequent, as Zoerer, of Vienna Lying-In Hospital, and Collins, of Dublin Lying-In Hospital, in a joint collection of 66,654 deliveries, find only three cases of imperforate rectum. It has been stated by others, though without any definite reference to give you, to occur about once in every 5,000 births.

*Pathology.*—The pathology of these malformations results from the arrested development of the parts in early fœtal life; and a glance at the development of the intestinal canal will show the method of production of the deformity, in some of its various forms. At the earliest commencement, the alimentary canal consists of a simple sac or bag, developed from the innermost layers of the Blastoderm, partly within and partly without the body, and in process of development the communication between the two portions of the sac is shut off and the portion within the abdomen consists of a simple tube—the mesenteron—which terminates at the anterior extremity of the embryo in a blind pouch, while at the posterior extremity a similar pouch is formed. The cul-de-sac of the anterior extremity of the embryo comes in contact and communicates with an invagination of the epiblast which is called the “Stomodæum,” while a similar depression of the epiblast at the posterior end of the embryo, named the “Proctodæum,” forms the anal orifice and communicates with the mesenteron. The greater portion of the malformations of the rectum and anus are due to the latter stages in the process just described being incomplete, or, in other words, to an arrested or irregular development of the proctodæum or mesenteron. The termination of the rectum in the genito-urinary tract is due, in addition to the arrest of development just mentioned, to a similar arrest of development in the perineal septum which separates the rectum from the genito-urinary tract; both in the early life of the embryo having a common orifice. The failure of development of the perineal septum explains the frequency of cases of imperforate rectum and anus in which there is a communication between the intestinal tube and the genito-urinary tract.

Bodenhammer's‡ classification of these malformations seems to be the best, and is as follows:—

I. Congenital narrowing of the rectum or anus without complete occlusion.

II. Complete occlusion of the anus by a membranous diaphragm, or by well formed skin.

III. The anus is absent, and the rectum ends in a blind pouch, at a point more or less distant from the perineum.

IV. The anus is normal in appearance, but ends in a cul-de-sac, and the rectum ends in a blind pouch at a variable distance above this point.

V. The anus is absent, and the rectum ends by a fistula at any point of the perineum or sacral region.

VI. The anus is absent, and the rectum ends in the vagina, bladder or the urethra.

VII. The anus and rectum are normal, but the uterus, vagina or ureters open into the rectal cavity.

VIII. The rectum is totally absent.

IX. The large intestine is totally absent.

‡Congenital Malformations of the Rectum and Anus, p. 290.

The diagnosis of the condition is simple, as it will indicate its presence within a few days after birth.

The 1st, or simple narrowing or lessening of the lumen of the canal, may be a form which may at times actually exist and be overlooked. The fact of the child not having free, easy defecation may be considered only due to a hardened state of the rectal contents, and we would be content to order some mild laxative, failing at the same time to appreciate the possible constriction. I would suggest it as a happy habit always to introduce an innocent gum catheter or bougie into the rectum, when we meet a case where defecation is more or less difficult or deficient within the first few days of life. The cases of atresia will only be noted after the child has failed to have a movement of the bowel within a few days of birth, and search for the anus has been made; or when the nurse accidentally discovers the absence during bathing. Where atresia exists the exact form can be determined through operative procedure.

The prognosis depends entirely upon the form. Cases of classes 1, 2, 3, 4 and 5—of congenital narrowing, occlusion by a membranous diaphragm; the rectum ending in a blind pouch or sacral hollow; the anus normal; the rectum ending above with an intervening septum; and the anus absent, the rectum ending above in the sacral region with a fistulous opening into any adjacent tissue or canal, are easily remedied, and in the majority of instances offer an opportunity to establish an artificial anus at or about its normal situation, and the prognosis is usually decidedly favorable, but to be so must be noticed early and operated upon before gangrene or rupture occurs. Mr. Curling reports 31 cases of rectum ending a blind pouch, with and without an intervening tissue. In 27 cases, attempts were made to find the bowel, the search resulting successfully in 16 instances, with 10 subsequent recoveries. Bryant records two successful results in the same condition in his own experience. The condition, as in figures 6, 7, 8 and 9 (where the rectum and large intestines are entirely absent; or the rectum empties into the uterus, vagina or bladder, or vice versa) is exceedingly unfavorable, owing to the fact that an artificial anus must be established in an abnormal situation, and the results are not at all encouraging. Death resulted in one of my own cases; an easy recovery in the other. Among my individual acquaintances experiences have been equally unfavorable.

Holmes says he has "not met with a successful case of this form." Bryant says "when the bowel enters into the bladder or urethra, the case is very hopeless."

Guersant opened the colon in the groin eleven times in succession and they all died. Bryant, on three occasions, did Huguier's operation, with only temporary relief.

Giraldes had one case in which the child lived  $2\frac{1}{2}$  months and then died of another cause.

On the other hand, M. Rochard (in 1859, Bryant) made a record of 10 authentic successful cases of Littré's operation.

Mr. Curling reports one of a boy, who lived eight years with an anus in the groin, but did still pass fœcal matter through the urethra. There is, also, still another case where one lived to be 26 years of age, and then died of intestinal obstruction, having been annoyed by occasional attacks all his life. Without operation they usually die within a few days of birth; children may, however, live and seem to do well and remain in apparent comfort for many days without any operative interference, and, of course, without stool. There is increasing distention of the abdomen, which accommodates itself to a large amount of food

taken. Of course, this is liquid, and it is true the greater part is absorbed or excreted by the bladder, the residue accumulating until nature lends its aid in the act of vomiting and limited relief is afforded. This vomiting may occur at frequent intervals during the days and this suffice for a stool and effect a continuance of life.

Cripps§ mentions the case of a child two days old who was brought to St. Bartholomew's Hospital with an imperforate anus. The parents refused to have any operation done, and took the child away. The case was brought back to the hospital one month later, and it was then observed that the child appeared fairly nourished, but that the belly was much distended; the parents stated that it had fecal vomiting three times a day. Mr. P. Harrison reports a case in which the child lived 33 days without operation, but had regular vomiting spells during the day.

In the November, 1891, number of the *Archives of Pediatrics* there is an abstract reference to a case reported by Dr. Wm. Hailes, Jr., where a child had a normal anus ending in a pouch, with an intervening septum of tissue. Mother refused operation, gave it anodynes to produce rest and sleep. For five weeks child seemed quite comfortable and improved. Sixth week, abdomen became very much distended and œdematous, with pitting of extremities. He says there was considerable vomiting of food mixed with bile, and sharp colicky pains. Eighth week mother consented. There was then enormous distension and it was very weak. Trocar was then introduced through the bridge of tissue without difficulty and the fluid yellow contents were emptied off; dilatation was continued and recovery resulted.

The treatment is purely surgical, each case requiring such surgical interference as may be indicated in its simplicity or its obscurity. The treatment in the first instance—a simple narrowing would be best—is that of gradual and repeated dilatation; the permanency of cure being very hopeful and encouraging. It may be carried out by the introduction of graduated bougies, or, as has been suggested, the oiled finger of the mother or nurse. If there be any constricting bands about, in, or adjacent to, the anus, they should be divided. In the second class, or in occlusion of the anus by a membranous diaphragm, the operation is simply cutting the intervening tissue, drawing down the rectum and attaching it to the outer edge of the wound. In the instance of a normal anus, the rectum ending some distance above in a blind pouch, a trocar should be introduced through the intervening tissue and search made for the rectal pouch, and if found it should be dissected out, drawn down and stitched to the edges of the anal wound. If not found in this way, it must be treated as all other rectums without external openings, by the perineal operation. If this operation be decided upon to reach the rectal pouch, it is the more simple and less dangerous one, added to which is the advantage of having the anus in or about its normal position, with a fair control of the bowel; it is worthy of note, in such cases, that the anal sphincter is often well developed in spite of the malformation of the bowel; the child should be placed in the lithotomy position, an anæsthetic being used or not, as may be the choice of the surgeon. In my own case, I preferred not to use an anæsthetic. If it be a female child, an additional opportunity for the search for the bowel is offered in the vagina. The tissues can now be divided in the median line of the perineum, remembering to make the deepest incisions posteriorly as offering the most room for safe exploration; the finger should occasionally be inserted into the wound in effort to detect any impulse which might be given by a

§Cyclopedia of the Diseases of Children, p. 254.

distended rectum. If such be detected a trocar may be introduced into the distended bowel to act as a guide. When the rectal pouch is reached, it should be incised and emptied, loosened from its attachments, and, if possible, the edges should be brought down and sutured to the outer edges of the wound.

If the rectum will not allow the outlet to be placed in its usual position, one may excise the coccyx, as has been suggested and practised by Verneuil, which greatly facilitates the search for the gut; and when found can more readily attach the edges of the rectal pouch to the skin at that point, which also allows for any contraction of the bowel which might occur. If the dissection of the perineum has been extensive, as is allowable in that region, without finding the bowel, one must then consider the abandonment of any attempt to reach the gut through the perineum, and then may endeavor to open the large intestine, either in the left groin (Littre's operation), or in the left loin behind the peritoneum (Amussat's operation), or in the right groin (Huguier's operation). Amussat's operation in the loin is objected to, and rather set aside, upon the fact of the difficulty in finding the descending colon, owing to its looseness and mobility below the splenic flexure, and because the relatively large size of the infant's kidney limits the space in which the operation is performed.

Huguier's suggestion to make the incision in the right groin to open the sigmoid flexure of the colon, based upon the observation that this portion of the intestines is frequently in young children curled over so as to assume this position, has not generally been accepted. He also says, if the sigmoid flexure be not found in this position, the cæcum or some other part of the large intestine may be reached and utilized. Experience, however, has contradicted that, and shows that the sigmoid flexure occupies much more frequently the left groin where Littre's operation is done.

Giraldes did 30 autopsies, in all of which it was found on the left side; while Bourcart in 150 post-mortems made to elucidate this point, found it to occupy its normal position in 117 cases. I believe that almost all authorities now accept Littre's operation, or laparo-colotomy in the left groin, which opens the bowel nearest its natural position, as the best procedure to adopt when it is impossible to establish a perineal opening.

This operation consists in opening the abdominal wall in the left side just above and parallel to Poupart's ligament, beginning at about the juncture of its middle and outer thirds.

There have been modifications and changes suggested in this operation, which, with the extent of operative means, the antiseptics or asepsis, the after-surgical care, are all purely individual or personal considerations of the surgeon; and it is not my privilege to define them here, but must depend upon the discretion of the attendant.

Conclusion: As regards the results obtained by the various operations for the relief of the symptoms due to imperforate rectum, there is no doubt that, in point of safety and as a matter of comfort to the patient, the weight of evidence is largely in favor of the perineal operation.

Cripps has collected 100 cases of the various operations for the relief of imperforate rectum; his table, although exhibiting a high rate of mortality (fifty per cent.), shows that the largest number of recoveries followed the perineal operation, and that next in number were those cases in which the colon was opened in the groin.

The number of well attested cases collected by Cripps, Holmes, and other surgeons, in which children with an imperforate rectum have been operated upon

successfully and have lived for years afterwards in comfort, shows that the operation for the establishment of an artificial anus, either in the perineum or in the groin, does not relegate the patient, if he survives, to a life of misery; and cannot, I think, fail to convince even the most conservative surgeon of the humanity and utility of operative interference in such cases, equally as much as one would suggest and do, if allowed, a colotomy for any intestinal obstruction in the lower bowel, or an intubation or tracheotomy for laryngeal or tracheal disease.

In illustration of the subject, I present the following report of cases which have recently come under my care:

CASE I. Two days old, white. Male, German parentage. Nurse noticed this morning, in washing, that the child had no anus, and I was asked to see it.

*Physical examination* showed the child to be well-formed, fair-sized, and healthy-looking boy. Head and extremities normal, chest examination negative, motion of body and limbs perfect, urinates normally, genitals well formed, normal buttocks, with normal perineum, but there is no anal outlet. About one inch posteriorly to the attachment of the scrotal tissue to the perineum can be seen a small smooth surface about  $\frac{1}{4}$  inch in all directions, in the centre of which seems to be a probe-sized opening, but upon examination of which there is found no inlet. There is a perineal crevice extending back toward the spine, ending just at the tip of the coccyx, where there is another sulcus or indentation, which also may be said to resemble an anus. This also has no inlet into the pelvis. Abdomen somewhat swollen, tense and tympanitic to percussion. Child nurses, seems well, except restless, as if uncomfortable. I made a  $\frac{1}{2}$  inch incision, just over and including the anterior impression of an anus. The tissue was penetrated to about one inch in depth, and after searching in the adjacent parts without finding the rectum, all further interference was deferred until next A. M., when Dr. Finney saw the case with me. The child at this time was more uncomfortable, has had no fæcal discharge through wound, which is clear. Abdomen more swollen; no vomiting, voids urine, with which there seems to be some fæcal loss. The entire perineum was now incised antero-posteriorly in mid-perineal line from scrotal border to tip of coccyx. The parts were cut freely until the sub-peritoneal tissue was exposed. A trocar was then introduced in all directions to the depth of about one inch, but all instruments seemed only to come in contact with dense connective tissue. At no time could one detect contact with anything which resembled the rectum, nor could one discern the least impulse which would characterize a distended rectum. Pressure made bimanually, *i. e.*, supra-pubic and in the wound, caused the child to void urine which was colored with meconium, which led us to believe we were dealing with a case in which the rectum had its outlet in the bladder. Colotomy was then suggested, but was declined by the parents. The child grew gradually worse, and passed fæcal lumps through the urethra during urination, on the fourth and fifth days, which was more confirmatory that the rectal outlet was in the urinary tract. The child died on the eighth day. No autopsy was allowed.

CASE II. Johns Hopkins Dispensary; a white, male child, æt. eight months, was operated upon immediately after birth, but not completely relieved. Examination shows a well grown and well nourished child. Chest examination negative, normal motion, abdomen negative. The perineum is normal, without an anus; but in the anal region, there are two holes, one made by the incision, which has partly retracted or closed,  $\frac{1}{2}$  inch from which, posteriorly, can be seen a smaller opening, which has been made by a spontaneous rupture of the parts. The child passes liquid stools comfortably through both openings but cannot pass solid stool, for which reason it was brought for treatment.

Dr. Halsted operated by cutting through the diaphragm, and found a normal rectum presenting itself, which was drawn down, and sutured to the perineal margins of the wound. Rapid recovery, with union of the parts, took place, and the child was dismissed with a normal rectal outlet.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 19, 1892.

The 262nd regular meeting of the Society was called to order by the President, Robert W. Johnson.

*Dr. Hiram Woods* read a paper on THE TREATMENT OF GRANULAR CONJUNCTIVITIS. (See JOURNAL, p. 402.) He exhibited patients treated by the method he now uses, viz., that of Dr. Knapp, which is the squeezing out of the spawn-like lymph follicles by means of forceps specially adapted to the purpose. Case I: A man with pannus of three months' duration; had been treated all this time with blue stone with no improvement. Forceps were used very gently, some granulations pressed out. Considerable pain and much bleeding from conjunctiva ensued. The following day the man's eyes were wide open and photophobia completely relieved. Squeezed out some more granulations. He came back next day with conjunctiva quite clear. Has not returned since. Case II: Girl with so-called diffused trachoma of two years' duration; was treated all last summer with blue stone. In November she was suffering intensely, the entire upper lid of the right eye covered with spawn-like soft follicular granulations extending over on to the ocular conjunctiva.

Two operations performed. At first nearly all the granulations of palpebral conjunctiva were squeezed out; at the second all those that had escaped in the first operation were destroyed. There was swelling and pain for a couple of days, these symptoms disappeared and photophobia also. There are still a few granulations in the retro-tarsal fold which will be removed. The palpebral surface is quite smooth. Case III. Follicular trachoma of long duration. Granulations of connective tissue variety buried deep in conjunctiva. Dense, heavy pannus along the upper part of the cornea, and the whole cornea vascular. Follicles pressed out with exercise of considerable force. Conjunctiva became perfectly smooth. After a month, inflammation was set up by a small amount of jequirity with the view of clearing up the pannus. The pannus cleared up, the photophobia has entirely disappeared and the eye is almost well. Case IV: A man, troubled with trachoma for four years, came to the hospital early in January, and was operated on without previous treatment. Granulations were of connective tissue kind. A great deal of thick, heavy pannus. Photophobia considerable, lachrymation much, and the whole eye congested. Granulations squeezed out by using considerable force. There was a great deal of pain and considerable reaction, and after two weeks the eye was watery and somewhat painful. There is now no watering, the eye is clearing up, the lid is smooth, and he is in a fair way to get well of his pannus. Two other cases, both in young Jewish women, were in the atrophic stage and very little could be done except to relieve irritative symptoms. Both suffering intensely from photophobia and lachrymation. One was operated on a week ago and is almost entirely relieved of photophobia. The other was operated on yesterday, and feels better to-day than before this operation. Two cases operated upon at the hospital never returned.



His experience with these cases, together with the experience of Dr. Knapp in his 114 published cases, leads Dr. Woods to the conclusion that this is the best method ever devised for the relief of granular conjunctivitis.

*Dr. J. E. Michael:* I was for a number of years Dr. Chisolm's first assistant at the Presbyterian Eye and Ear Hospital, and I remember very vividly the many cases of trachoma that came to us day after day, and month after month, and year after year, to have nitrate of silver or blue stone applied, and it was our habit to regard these cases as almost hopeless. I have noticed, of course, a gradual improvement in some of them, which would go to a certain point and then stop. I have not seen any cases which have shown anything like the improvement seen in these cases exhibited by Dr. Woods. I want to express my satisfaction that so important an advance has been made in treating such an obstinate and troublesome pathological condition.

*Dr. Wilmer Brinton* read a paper on PHLEGMASIA ALBA DOLENS, with report of three cases.

In about 1,100 cases of obstetrics Dr. Brinton has seen three cases of phlegmasia alba dolens, or the so-called "milk-leg." The various views as to its causation were given. It is now generally held that it is caused by phlebitis, that phlebitis being an extension of the disease from the vessels of the uterus. Virchow claims it to be due to a physiological thrombosis. Case I: Mrs. D., was confined in November, 1884, second child. Labor rapid. Lying-in period uneventful until the 11th day. Temperature and pulse normal for 7 days, the record no longer kept. On the 11th day the patient was found in the bed crying with pains in the left leg. Pulse 120, temperature  $101\frac{1}{2}$ . Had a chill in the morning, followed by feeling of malaise and intense pain in the left leg. The leg was swollen and hot to touch. Swelling much greater the next day. Pulse and temperature became normal in a few days. Swelling gradually disappeared, first from foot, then from the calf, and then from the fleshy part of the leg. It was three months before she ceased to complain of stiffness and soreness. Case II: Mrs. S., confined by a midwife on October 8th, 1888. No trouble or complications. Remained in bed till the 10th day and then resumed her domestic duties. On the night of the 14th day after confinement, had a chill, followed by pain through the body, and intense headache. The next morning was somewhat better, but could not move the left leg without pain, and it was rapidly swelling. Dr. Brinton was called in the next day and found the patient was in bed, pulse 120, temperature  $101\frac{1}{2}$ . Complained of a general feeling of malaise, severe headache and very severe pains in the left leg. The leg was much swollen and œdematous, especially in calf and about the ankle. Especially tender to touch on the inner side of the popliteal space. In two days swelling about the ankle began to disappear. In 17 days got out of the bed and soon began to move about and attend to household duties. Case III: Mrs. T., delivered September 1st, 1891, of twins. It was a case of placenta prævia centralis, with much loss of blood, from which the patient rapidly recovered. Lying-in period uneventful, although pulse and temperature slightly above normal; pulse 85 to 100 and temperature  $99\frac{1}{2}$  to 101. On the 10th day set up for a short time. On the evening of the 11th day the temperature rose to 104 and pulse to 136. Had had decided rigor about midday. Next morning, pulse 100 and temperature 101. Examination revealed a case of septic endometritis, due, doubtless, to lacerated cervix. The "skilled" nurse had given the injections in such an imperfect manner that no benefit had been derived. On the 14th day from the beginning of the attack the left leg showed marked signs of phlebitis. Pain first felt below Poupart's lig-

ament, and extending down the thigh to the leg. The leg became greatly swollen. In ten days painful symptoms subsided, patient moving the limb without much pain, when suddenly the pulse became rapid and the temperature 104 and the right leg became involved more extensively than the left. About seven weeks from time of delivering she was able to be removed to Washington. She is now enjoying the best of health.

The treatment of these cases was by internal administration of quinine, opium, aconite and phenacetin, and, locally, absolute rest of limb, application of flaxseed poultices to certain parts of limb for a few days, and later the limb was rubbed from time to time with camphorated oil and a flannel bandage applied daily from toes upward. In case III the uterus was washed out daily for some time with bichloride solution.

*Dr. W. S. Gardner:* I would like to ask Dr. Brinton if he kept the temperature record of that first case up to the time she was attacked.

*Dr. Brinton:* I did not. It is now several years since, but I am satisfied that the pulse and temperature were practically normal; if not, I would have made a record of the case.

*Dr. Gardner:* There is quite a difference between a "practically" normal temperature and an actually normal temperature. I believe that if the temperature records of all these cases are kept accurately you will find that few, if any, will have a normal temperature from the time of confinement till the time that phlegmasia alba dolens comes on. I think it is a fact that is about as well established as anything connected with septic troubles of the puerperal state that this is one of the conditions that we have as the result of septic infection; that it is nothing more than a connective tissue inflammation in the leg, due to sepsis. The clot in the veins is entirely a secondary affair and has nothing materially to do with the condition. There are many post-mortems reported in which there were no clot and no phlebitis. Even if this were not the case, the retarding of the return flow of blood would not give the condition found in phlegmasia alba dolens. Retarding would give you a simple œdema; in phlegmasia you have in addition to œdema what seems to be more of an inflammatory condition, although it is not associated with the redness of ordinary inflammation; it is an infiltration into the tissues instead of a pouring out of serous fluid into spaces beneath the skin, so that the limb becomes practically solid and does not pit readily on pressure.

So far as the treatment of these cases is concerned, it is just the treatment of all our infectious diseases except syphilis and malarial fever. You cannot do anything with them; they either get well or they die. You cannot cure typhoid fever, nor scarlet fever, nor phlegmasia alba dolens, nor troubles where there are micro-organisms developing in the tissues. You can only treat the symptoms as they arise.

*Dr. J. E. Michael:* The question as to the necessarily septic nature of phlegmasia alba dolens is not by any means settled and Dr. Gardner's statement that a careful record would in all cases show a rise of temperature or other conditions indicating a septic state of the patient is not carried out by the facts in many instances. I am convinced that Dr. Brinton's cases are as he stated them to be. He took the temperature for a certain number of days, and finding no rise did not take it again. I have seen one case of phlegmasia. The woman was dropsical, badly nourished and badly cared for. She had general œdema and œdema of the lungs, and every evidence of advanced kidney disease. She was confined successfully. For several days her temperature was normal, that is, under 100°, for we regard, in such cases, anything under a hundred as normal. On the 12th day

there was the sudden occurrence of pain and the other symptoms which Dr. Brinton has given as indicative of beginning phlegmasia alba dolens and the case turned out to be so, and had a fatal issue. The uterus, vagina and everything connected with the generative organs were absolutely free from any evidence of previously existing inflammation. There was a clot in the femoraliliac vein which had undergone softening and was described by the pathologists as the "puriform softening" of Virchow. I think there is a question if there was anything which comes under the description of puerperal septicæmia and its various manifestations. What adds to the interest of this discussion is the statement made by Dr. Brinton, which is in accordance with our histories and experience, that cases of phlegmasia alba dolens occur, as a rule, in patients having a normal puerperium. The condition of the blood, or whatever it may be which predisposes it to easy clotting, is undoubtedly, according to the views of Virchow, responsible for its clotting under these circumstances. I am convinced that at least a portion of these cases are not associated with distinct phlebitis, but are the result of primary clot formation and do not begin till the clot is formed.

The other side of the case, and one that is taken by a good many, including Dr. Gardner, is that phlegmasia alba dolens always indicates a septic condition. I am inclined to think that there is a septic condition which produces, clinically speaking, the same condition which we find in phlegmasia alba dolens. We have the occurrence of phlebitis in the neighborhood of the generative tract and in the adnexa and we may have a phlebitis which would involve the general vein and would produce the clot and the general train of symptoms following. I do not think we have grounds for sepsis in all the cases. I believe the only satisfactory solution can be arrived at by gathering together all possible information about the occurrence of this disease in lying-in hospitals now and comparing it with its occurrence in years gone by when septic conditions prevailed to such an extent. Virchow says that in the examination of these clots in cases that terminate fatally we have an appearance of pus surrounding the vessel and which would on careless examination be taken for pus, but in which the most scrutinizing examination reveals no pus and no bacteria. So I am inclined to think that we can have phlegmasia alba dolens with no septic infection whatever. I am inclined to think that two of the cases spoken of by Dr. Brinton were of this kind.

Another point bearing on this subject in a most practical way is that in by far the great majority of cases where we do have positive puerperal septicæmia we do not have phlegmasia alba dolens.

*Dr. J. H. Branham:* As Dr. Michael has said, it is difficult to decide whether all cases of this disease have the same cause. Where there is a clot in the vein if the trouble begins as an infection, the organisms enter some of the uterine vessels and gradually extend to the larger vessels; this is the theory maintained by many good observers. If it is simply clotting of blood extending from smaller veins into the larger ones, this can occur without sepsis. Some cases are not accompanied by these clots at all; in these cases the swelling is due, I think, to stoppage of the lymph vessels.

The occurrence of chill and the rise of temperature and pulse in these cases looks as though there was some form of septic infection. I do not believe that simple stoppage of circulation without some infection in addition causes these symptoms. As to how the infection gets there, there is some doubt. It is well known that we may have a very late form of sepsis in obstetrical cases. Without any previous rise of temperature, decided septic trouble may come on ten to eleven days after labor. Either there was a late infection or there was at first a

very slight infection, and then it took time for sufficient development of the organisms to produce decided septic symptoms.

*Dr. W. S. Gardner:* With reference to the history of these cases: We know that it is an extremely rare disease. Tyler Smith gives us a history of one man having three successive cases of labor in each of which phlegmasia alba dolens occurred. There was another series of three successive cases in this town a few years ago. While these series of cases are very short and might be considered as coincidences in any ordinary disease, yet, considering the extreme rarity of phlegmasia alba dolens, I think a series of even three cases is strong presumptive evidence that it must be due to something which can be communicated by some one to the patients.

If the remarkable degree of disorganization which is found in these cases is not due to micro organisms, how, then, are you going to account for it?

*Dr. Brinton:* I am inclined to think that sepsis is the cause in a certain number but not in all cases.

As to normal temperature: In the vast majority of cases, I think that the temperature in normal child-bed will be 98° to 99°, and that in many cases there is a normal temperature of 100.5. In some cases where the temperature has been 100°, the lying-in period has been as uneventful as where the temperature was 68.5°.

1603 N. Broadway.

W. T. WATSON, M. D., Secretary.

#### TUBERCULIN AND CANTHARIDIN.

In the *Southern Med. Record*, March, 1892, Dr. Von Ruck, who has a large sanitarium at Nashville, N. C., writes of these remedies as follows:

I have continued the use of tuberculin, first, because I have been able to so administer it as to utterly avoid fever, *malaise*, or loss of appetite or any other unfavorable or disagreeable symptom, and because the patients have made remarkable local and general improvement under its use, and a gain in body weight has been observed in almost every case. Second, because from my study and investigation of its action when given in proper doses to suitable cases under certain precautions, I have come to the conclusion that its action upon tubercular tissue is selective, acting as a gentle stimulant or irritant to the periphery of the tubercular tissue, whereby the local nutrition is benefited, the encapsuling of the tubercle is favored and the advance of the disease arrested, through the increase of the circulation, whereby more blood reaches the affected part in which the artificial stimulation is induced. It is therefore an aid to the local nutrition of the affected part, but it is only one aid, and can never be depended upon to the exclusion of many other aids.

I believe that Liebreich's proposition of cantharidin as a remedy is based upon the same principle and has seemed beneficial in the few cases where I have had occasion to employ it. Its stimulating and irritant action is not upon tubercular tissue as such, but upon all tissues the subject of present irritation and inflammation. I have, however, seen several abscesses from its use under every antiseptic precaution, and have exceptionally seen the injections followed by rigor and rise of temperature to 102.5° F., lasting several days, when two-tenths of a milligramme had been injected, which caused me to reduce the doses and would lead me to its abandonment if I should find such occurrences unavoidable.

A case of acute general dermatitis, with exfoliation of epidermis, caused by a small dose (2 grains) of quinine sulphate, is reported by Dr. Amelia Erbach, of Washington, in the *Archives of Pædiatrics*, March, 1892. Hair and nails were likewise shed.

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BALTIMORE, APRIL 2, 1892.

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### Editorial.

#### MEDICAL APPOINTMENTS.

It is decidedly a waste of time and printer's ink for an humble individual to venture a suggestion to the average *practical politician*. Our statesmen are reasonably certain that they understand their business in all its manifestations and sinuosities, and are not eager for advice. In spite of all this, however, we feel impelled to make a suggestion, which will probably be classified as utopian and will be "not only doomed, but damned."

It is a perfectly well recognized fact that not only in one State or city, but in all, we now and then see physicians appointed to strictly medical offices who are not only totally unfitted for the place, but who are decidedly objectionable to the profession. Many of these offices are exceedingly important to the public welfare, and the public has a right to demand that suitable men be selected to fill them.

Now the profession knows full well, even if the public does not, that the political doctor is as a rule more of a politician than a doctor. He is ready to be port physician, or coroner, or health officer, or lunacy commissioner, according to the salary, the "pull," or the perquisites.

It becomes obvious at once that, in a large city at least, it requires very special qualifications for many of these offices. A health officer with no knowledge of modern sanitary measures, a lunacy commissioner who has made no study of insanity, a coroner's physician, ignorant alike of pathology and medical jurisprudence—these things are absurd.

But are there not in many, if not most, of our large cities, just such men filling some of the offices named? Of course there are many medical men filling political offices, who are eminently fitted for the positions, but unfortunately these are rather exceptions, and the tenure of their positions is always insecure. It is manifestly impossible for the appointing power to select suitable medical men.

There are certain minor appointments that any respectable physician can fill, but there are in every city and State offices that should only be filled by men who are professionally qualified.

Now for the utopian remedy, which is to *allow the State Medical Society to send in to the appointing power a certain number of names from which a selection can be made.*

If the political doctor is endorsed by the State society, of course he is eligible, but not otherwise. Of course this plan is open to many objections, but on the other hand it can be made to correct many of the abuses to which we have alluded.

No man who happened to be obnoxious to the profession could be appointed to a medical office.

The laity have to smile and sneer at professional etiquette and never seem to understand that the medical profession is as much insulted at being represented by a quack, as the clergy would be if represented by one who had been expelled from his pulpit, or the legal fraternity by a man who had been disbarred. The medical profession is in a certain sense responsible for its members in office, and if these latter are incompetent the profession gets a share of the blame. Such being the case it is hard that we can have no voice in the selection of medical men to fill important medical positions. Doctors as a rule are very long-suffering individuals and unfortunately often "pass on and are punished."

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#### THE PROBLEMS OF "PRACTICAL POLITICS."

The preceding contribution to our editorial column was sent us by a medical friend in whose uprightness of purpose and love for the profession we have every confidence; therefore we have inserted it intact. We cannot, however, make ourselves responsible for its statements, for several reasons.

*First:* We do not know what particular persons are referred to as unworthy of office. Perhaps the writer was suffering at the time from "undue reflex excitability of the centres of indignation." We have come into contact recently with but one of the doctors who hold political office—namely, the Health Commissioner, and his actions seemed quite judicious. The occasion was the report of a case of scarlatina. We thought, erroneously, that the patient was going to die, and, as is our custom in such cases (to avoid trouble over the death certificate), sent in a report of the case to the Health Office. We expected either that no attention at all would be paid to our notification or that some ex-saloon-keeper would, after a few days, drop in and look around the patient's front parlor. Instead of this, a circular containing very excellent directions concerning disinfection was sent by the Health Office, which we recommended earnestly to the attention of the mother of the patient. If the Health Officer is going to be as sensible as this all the time and will not unnecessarily inflict the farce of an inspector's visitation upon our patients, we will be glad to notify him of all contagious cases, even where we do not expect a funeral.

*Second:* Because we do not sufficiently understand political affairs. We are frequently puzzled to make out the meaning of the terms used in "practical politics" and are ever anew filled with surprise at the apparent difficulties with which measures of public benefit meet in the halls of legislation. What, for instance, does the word "pull" used by our writer signify? In a conversation with a business man a few days ago concerning an enterprise for public improvement, he stated that it was delayed in the legislative halls because its promoter refused to "go up and see the Colonel." We were informed that this trip to the "Colonel's" residence (which appeared to be very expensive) was a necessary item in the enactment of bills of commercial importance; the "representatives of the people" being apparently unable to make up their minds how to vote (or even to consider a bill) until the trip was accomplished by the promoters. Again we were puzzled, in reading of the druggist's recent meeting concerning reduction in telephone rates, to understand why it was thought necessary to have an agent "on the spot" in order to secure legislation. A friend informed us that we had misunderstood the statement; that a sum of money must be placed on the spot; but even this is obscure. Will not one of our better informed readers prepare for the use of physicians a little treatise containing "A Simple Account of the Ways of the Practical Politician; with a Dictionary of the Obscure Terms used by Specialists in Practical Politics"? Then perhaps we may enter the arena of political censure.

*Third:* Because we have little confidence in spasmodic and diffuse efforts after political reform. The "practical politician" does not care a continental for temporary and isolated gusts of reform. He knows well enough if he "lies low" it will soon all blow over. What we need is a permanent and responsible association of medical men; which shall have for its object the bold and outspoken censure of *individual* evils by name, and the institution of strong, united and persistent movements for special reforms and advances in medical matters of professional or public interest. The editor is not fitted to organize such an association, but will go earnestly into it if it is undertaken by competent organizers.

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### Medical Progress.

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#### A CASE OF LARYNGEAL VERTIGO OR LARYNGEAL EPILEPSY.

In the *Medical News*, March 19, 1892, Dr. W. C. Phillips, of New York, reports a case as follows:

Two days before I saw him, during a paroxysm of coughing, without premonition of any kind, he fell suddenly to the floor upon his back, entirely losing consciousness. The attack lasted but a few seconds; he rose from the floor feeling perfectly well, with no pain or unpleasant feeling of any kind, and with no vertigo either before or following the attack. The sensation was exceedingly pleasurable, and upon being asked how he felt after an attack, he exclaimed "I felt as though I had been in heaven."

Following the first attack he had one nearly every day for four days. They sometimes occurred while he was in bed. As a rule, he stood up when coughing and leaned forward with his hands upon a chair or some other object for support, but he invariably fell upon his back during the attack. On one occasion he fell upon

the street, but was up again before any one reached him. In every instance the loss of consciousness came on during a paroxysm of coughing, but he had many paroxysms of cough which were not followed by loss of consciousness. He had had four when I first saw him, and loss of consciousness was complete in all, and the sensation that gave rise to the cough was the same as he had experienced in former years. He did not bite his tongue, foam at the mouth, or groan or shriek; but on several occasions his mouth twitched convulsively during the attack, and his eyes remained open. He had, in all, twenty fits, and on one day he had five fits between 3 and 9 P. M. In every instance there was complete loss of consciousness. I instructed his wife to watch him carefully during the attacks; she reported that his face became very blue, and that unconsciousness would terminate in from five to fifteen seconds, when he would arise and walk as steadily as before. On two occasions he complained of a sensation of pressure in the arms and in the region of the deltoid muscle, and, again, of what he termed "smarting of the brain." The patella reflexes were normal.

Examination of the upper air-passage revealed a general hyperæmic condition with no specially sensitive areas. There is polypoid degeneration of the middle turbinated bones, an exostosis on the septum, on the right side, with a posterior hypertrophy on the right inferior turbinated bone. There is no varix at the base of the tongue and only slight hypertrophies. His uvula was amputated thirteen years ago on account of its relaxed condition, which caused cough. The larynx, aside from a subacute inflammation, is normal in appearance. The vocal cords are congested at the edges, but approximate perfectly. There are no signs of paralysis.

After about ten days' treatment these attacks disappeared entirely, and have not recurred up to this time (February 18th). This was carefully regulated, his bowels opened with a brisk cathartic, and he was given fifteen grains of bromide of sodium, three times a day, in conjunction with five-minim capsules of eucalyptol, four times a day. The eucalyptol relieved both the cough and the profuse discharge in a very few days, and he has made a good recovery. He had no other medicine except a general tonic.

#### IS OUR HEALTH DEPARTMENT TO CONTINUE AN ASYLUM FOR POLITICAL BUMMERS?

"Notwithstanding Governor Markham's manifest executive myopia and other visual perversions which concealed from his enlightened view the gross criminality of exposing otherwise honorable men to dangerous temptations by creating an entire health board from among members of one political party, the *Pacific Medical Journal* had, in common with the profession at large and other citizens, entertained great expectations from our new Board, hoping that they would speedily give the city a well organized Health Department, in which ignorant and unscrupulous politicians would be superseded as secretaries, health inspectors, public vaccinators, etc., by learned and humane physicians, who would take pride in their calling and honestly endeavor to protect the people against the inroads of filth-engendered diseases. The time for such reform was opportune, revolt against political bossism was in the atmosphere, and the Board knew that it would have the moral support of the taxpayers as well as of the medical profession in refusing to become mere puppets ready to dance to wire-pulling bosses. A health department is no place for politics, and the sanitary administration of a great city—and for that matter of a little village—should be entrusted to the keeping of such only who, being upright and conscientious, have fitted themselves specially for



the work by supplementing their medical studies with a thorough course in hygiene. It is true that this most important branch of medical science is now taught in many of our medical schools, being included in the regular curriculum; but the instruction given is too elementary, and sufficient time is not devoted to it to make the average physician an efficient, practical sanitarian. This, however, will be remedied as the public learn the value of prevention. But while an ideal sanitary service is not attainable in the present state of our civilization, we do protest that to wantonly sacrifice human lives for the sake of placing a little patronage in the hands of a few low, contemptible, avaricious politicians is not the province of a board of health."

We did not write this. It came from the wicked city of San Francisco, which is the home of sand-fleas and corruption. The editor of the *Pacific Medical Journal* ought to come East and see how we fill our health offices in Maryland.

#### MANIFESTATIONS OF "LA GRIPPE" IN CHILDREN.

Our own experience inclines us to believe that the prevailing influenza has been milder in children than in adults. We have lost no children from it, and give a favorable prognosis in the case of young people.

In the *Archives of Pædiatrics*, March, 1892, Dr. C. W. Earle, of Chicago, presents an elaborate treatise on the above subject. He says: "No age has been exempt from the ravages of this infection, and if children have been spared in other epidemics they did not escape the present one. Nursing babies at four months of age felt its influence, while a large number between one and three years suffered. Quite as many under the five-year mark were affected as between five and ten years." He quotes one observer who says that the grip is the more severe the younger the child.

The article is too diffuse for easy condensation. We may, however, quote two paragraphs, one in regard to the time of its manifestation among the younger half of the population; the other in regard to the epidemic of the typhoid fever which followed it.

"One significant fact which presented itself to me, and to which my attention has been later attracted in an examination of the literature bearing upon this subject, is that children do not suffer from this disease until late in the epidemic. This fact was not noticed in the epidemic of 1891-92."

"In the city of Chicago, closely following this terrible epidemic which prevailed alike among children and adults, has followed a most severe epidemic of typhoid fever. Just what its relation to the previous occurrence of influenza may be, I cannot at this time state. Children were affected with *la grippe* and their general nutrition greatly reduced, then followed a large number sick with the typhoid fever; and now, whether there was a direct relationship between the two diseases, or whether the systems were weakened by the first affection so as to make it more easy for the typhoid to gain entrance, I reiterate, cannot now be unquestionably stated. Dr. Foster writes me his belief that the poison of influenza so weakened mucous surfaces that the germs of typhoid had an easy and favorable nidus. It is hoped that future observations will enlighten us on this subject."

#### ARTIFICIAL MATERNITIES.

"It's an ill wind that blows nobody any good;" and so the decrease in population in France is leading patriots to put forth renewed efforts for the saving and development of infant life. A correspondent of the *Archives of Pædiatrics*, March, 1892, writes:

A number of the towns in France have been studying measures to prevent the

steady decrease in population in the country, and have adopted one notion that may have its application, if extended to other places. It is to prevent the death of the children born before term by establishing artificial maternities, where the use of the hatching machine, or "couveuse," could be given to the public at a small rate, or for nothing, depending on the case. Some of the cities, like Marseilles, have had a meeting of the city councils, and have passed laws regulating such establishments, and have voted certain sums towards their maintenance, and charitable persons have been asked to contribute towards them, not only as a charity, but also as a patriotic saving of soldiers to the country. An automatic *couveuse* is used, based on Dr. Auvard's model, which has been improved. Each room of the place used may contain a dozen of the hatching machines, and one or two attendants can attend to the children placed in them. It is hoped in this way to save many infants born before term, belonging to poor people who either could not, or would not, provide such treatment. It is also thought that, raised in this way, away from the hospitals, such children will have a better chance than when put into such apparatus in the obstetric wards of the hospitals, as at present.

#### ARKANSAS HAS IT.

Writing in the *Courier of Medicine*, February 1892, Dr. Barr says:

As before stated, the uterine glands normally secrete a fluid which, under the stimulus of intercourse, is increased, and is of a greater specific gravity than the semen.

When intercourse occurs, the two fluids are mingled together. The secretion of the uterus is suspended from the inside of that organ, and requires more than the force of gravity to detach it. Therefore, when the semen comes in contact with it, according to the law of diffusion of liquids, they become mutually diffused together, and the semen being of less specific gravity will, of course, rise to the top, and thus is conveyed into the cavity of the uterus.

Often have I seen this secretion suspended from the inside of the uterus in considerable quantity, so much so that it would fill the os uteri and extend in considerable quantity into the vagina.

Upon the removal of this fluid it will be found to be saturated with the semen, thus furnishing unmistakable evidence that it is the means by which the semen finds access to the cavity of the uterus. As to the exact locality that the ovum comes in contact with the semen, I am unable to say; but as I can find no reasonable means whereby the semen can be conveyed any further than the cavity of the uterus, it appears to me to be the only logical conclusion, that pregnancy takes place in the cavity of the uterus, and not in the Fallopian tubes, or on the surface of the ovary, as some physiologists have supposed. Whether the uterus ceases to produce this secretion after the menopause, is a question I have not had the opportunity of determining; and also whether a lack of this secretion may not be the cause of some of the cases of sterility.

And to think of the pains heretofore taken by gynæcologists to remove these ladders of ropy mucus by which alone the spermatozoa may hope to climb into the uterus!

#### LOCAL ABSTRACTION OF BLOOD IN SCIATIC NEURITIS.

I know of no standard work which says a word about this method, and I have not seen anything concerning it in any of the journals which I have taken for twenty years; second, in well-selected cases, and taken before permanent pathological changes occur, I believe there is no remedy that will act so quickly both to relieve the patient and to bring about so rapidly a subsidence in the inflammatory process; and, thirdly, it is the most rational treatment, and the most

prompt remedy we have in the purely inflammatory types of the disease. When one cupping does not have the desired effect, I do not hesitate to repeat it once, or even twice.

The patient should be kept in bed, between blankets, and perspiration encouraged. The limb should be kept absolutely quiet, but I do not believe in the straight splint. I have suffered many times with the disease since 1872, but never very severely, and my experience is that the easiest position of the limb is to have the thigh slightly and the leg considerably flexed. Under these circumstances the patient can lie on his back on either side, which is a great comfort to him. The use of adjuvants may be necessary or advisable, such as circumstances may suggest. I would especially advise the use of morphine and atropine for a few days if there is any remaining pain after cupping.

Before discharging the patient he should be fully advised to be careful in the future not to strain the sciatic or expose himself to catching cold.—Dr. Gundrum, *Therap. Gaz.*, February, 1892.

#### STOMATITIS MATERNA.

At a recent meeting of the Hodgens Medical Society, Dr. F. C. Smith read (*Gas City Med. Rec.*, March, 1892) a paper on this complaint.

He said the majority of cases of stomatitis materna was found in suckling women, a few during pregnancy. Tendency somewhat hereditary, blood crisis, nervous influences and digestive processes seem to be all involved in the cause. The local symptoms are ulcers in the mouth, inflammation, sensation of burning or scalding and a peculiar redness. The digestion is usually faulty. Treatment is good, nourishing food, tonics, with application of argentum nitras to ulcers, gargle of rus glabra, fresh air and alteratives.

Dr. Amerman spoke of the microbes as a cause, also referred to the nervous disturbance. Antiseptics and alteratives serve the best purpose in the way of treatment.

Dr. Adair said he believed it a local disease, manifested in the mouth.

Dr. Cole said the nervous system seems to be much disturbed. Bromide, potassium and mercury served about the only useful purpose. Mouthwash is of no benefit.

Dr. Halley said the disease was reflex in a great measure and spoke upon the peculiar changes incident to child-bearing. The best local treatment he has ever tried is chlorate of potash and hydrochloric acid. Tincture of iron is objectionable, and chlorate of potassium solution does little good. The above mixture is quite agreeable to the patient. To correct the acidity of the stomach bismuth may be used with advantage.

#### RELATIONS BETWEEN CHOREA AND EPILEPSY.

In closing an article upon this subject, Dr. Trowbridge (*Alienist and Neurologist*, January, 1892), says:

The conclusions I have drawn on this subject are as follows:

First. There is an intimate relation between epilepsy and chorea; both diseases being due to disturbances of the motor and intellectual centres of the brain, which differ only in the degree of intensity.

Second. Choreia predisposes toward epilepsy and epilepsy toward chorea—the former being the most frequent condition.

Third. Choreia in one generation may be transmuted as epilepsy in the next or succeeding generations, or the epilepsy may appear first and the chorea in the following generations.

Fourth. That a neurotic taint in the parent or parents may make one child choreic and another epileptic.

Fifth. The disease may exist simultaneously but in these cases they are in inverse ratio, *i. e.*, the more violent the chorea the less frequent and severe the epileptic convulsions and *vice versa*, the more violent the epilepsy the less marked are the choreic movements.

Sixth. That in cases of chorea and epilepsy there is more or less mental impairment.

### Medical Items.

One of the best remedies for sprains is the application of hot water as hot as can be borne, repeated frequently; the addition of chloride of sodium to the water is beneficial.

Two cases of typhus fever are reported from Philadelphia. The patients sisters, one of whom had recently arrived from New York, where she was said to have been a nurse in Bellevue Hospital.

The New York State Assembly Committee on Codes has agreed to report favorably the bill amending the capital punishment act of the State. The bill does away with the electrical chair and substitutes hanging.

Boxes filled with sodium acetate are used in the French railway carriages as heat-producers. They are filled with the salt in a solid state, which is liquefied by putting the boxes in hot water, and during the five or six hours that it takes to solidify gives out heat steadily.

This clipping from a dental journal might apply in medicine:

An unkempt, slovenly, dirty dentist is a nuisance. If you can't afford nice professional clothes, shut up shop and earn them at the anvil or in the potato patch. Look neat and clean anyway. Starve yourself if necessary, but look presentable. Keep your mouth clean, too, and your breath. Away with that nasty stuff that so defiles the whole body. The idea of burning it in your mouth and making a chimney of your nose! It is an offence to your best customers.

The Commencement of the Baltimore Medical College was held Wednesday evening, March 23, in the Lyceum Theatre. Eighty graduates (from a class of 86 applicants), received diplomas. The first prize was awarded to James T. Johnson, of Alabama, who is appointed Resident Physician at the Maryland General Hospital for the coming year. The second prize was taken by Charles Francis Dawson, of Maryland, who has been appointed at a very good salary to prepare microscopic specimens for the Chicago Exposition, on behalf of the Agricultural Department in Washington. The other prizes were taken in order by Ralph Elmergreen, of Wisconsin; James M. H. Rowland, of Maryland; J. Henry Martin, of New Jersey; John C. Twitty, of North Carolina; and George Herbert Altree, of Florida. The grade of the class on examination surpassed that in any previous year.

Any one sending the following numbers of the JOURNAL: Vol. XXIV, 1890-91, Nos. 1, 9, 12; Vol. XXVI, 1891-92, No. 1, will be paid ten cents for same.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.

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## CONTENTS

### ORIGINAL ARTICLES.

- The Blood in Disease. By Joseph T. Smith,  
M. D., Baltimore. . . . . 507
- Two Cases of Ovarian Sarcoma. By L. E. Neale,  
M. D., Baltimore. . . . . 512

### SOCIETY REPORTS.

- Clinical Society of Maryland. Stated Meeting  
held March 4, 1892. Buphthalmos. Osteomye-  
litis. Appendicitis. . . . . 518

### EDITORIAL.

- A Danish Effort to Provide Pure Milk. . . . . 523

- The Medical Law. . . . . 525
- The "Buffy Coat." . . . . 525
- Editorial Note. . . . . 525

### REVIEWS, BOOKS AND PAMPHLETS. . . . . 526

### MEDICAL PROGRESS.

- Nasal Hydrorrhoea Caused by Polypi in the An-  
trum.—Treatment of Stricture by Diet.—The  
Swedish Cure for Drunkenness.—Ventilation  
by Perforated Window-Panes. . . . . 527

### MEDICAL ITEMS. . . . . 527

## Original Articles.

### THE BLOOD IN DISEASE.†

BY JOSEPH T. SMITH, M. D.,

Professor Materia Medica and Therapeutics, Woman's Medical College, of Baltimore.

Through all medical time the blood has been looked upon as a fluid which could furnish more or less valuable information in diseased conditions. A full and complete knowledge of its composition and activities, it was thought, must of necessity show changes in many, if not in all, diseases. Opinions as to what the alterations are and what they teach have from time to time undergone such radical changes that it is difficult when reviewing them to know just where we stand and just how much we really know; how much from the mass of changing opinions we shall select out and, putting it aside, say "thus much, at least, is certain."

Few conditions bring the blood, as a factor in disease, so prominently before us as inflammation. The time and labor spent by our forefathers in studying the "buffy coat" and what it indicated were no less than that spent by eminent men of the present day in studying, not the blood, but the cells, concerned in the process of inflammation. Watson, in his authoritative work published in 1858, says "but it (the 'buffy coat') does not occur at all except in certain conditions of the system; and it belongs so especially to the state of inflammation, that blood having the buffy coat upon it is often spoken of as inflammatory blood, or with less propriety, as inflamed blood. Both these expressions, indeed, are incorrect; for in-

†Read before the Clinical Society of Maryland, March 18th, 1892.

flammation sometimes exists without buffy blood and buffy blood sometimes occurs without inflammation. The phenomenon is, ever, upon the whole, a very valuable index of the nature of many cases of disease and an important guide in their treatment." To him and those of his day the "buffy coat" meant a great deal, and they fondly looked for the time when a future generation would learn from the "buffy coat" much more than they; but the generation has come and that from which such great results were to flow is no longer heard of; what was then the chief concern, namely, the blood, has become of secondary importance and the cells are now looked upon as the material from which we are to construct a true and lasting theory of inflammation; one which shall not, like the "buffy coat," be soon forgotten, but one which shall be made more and more certain as time goes on. All this admits of a ready explanation, but at the same time causes us to look with at least some degree of suspicion upon much that is deemed knowledge at the present day. The cellular pathology so revolutionized the study of disease that the microscope under its guiding influence means so much for us in our study of disease that it is to be hoped we are not giving it too high a place in our esteem. We but seldom bleed; the blood no longer means for us what it did in the days of our forefathers; we have no blood to examine except such as is obtained from the end of the finger by the prick of a needle, the fluid even then flowing too freely for the microscope. From our teachings, then, and a form of practice which has set aside almost entirely the drawing of blood, the opportunity to examine any considerable quantity of blood is wanting. Such being the case, who shall say that the blood has not secrets which it refuses to yield to the microscope? May there not be changes, chemical and vital, which can only be known when blood in considerable amounts is examined? Were bleeding allowed now, as formerly, and the blood so obtained subjected to such a thorough examination as is made possible at the present day, it is impossible but to believe that it would reveal much of value in our study of disease. The flow of the blood in its vessels, its normal activities and the effects of foreign substances upon it, have been so studied that our knowledge in that direction is truly surprising, but the blood in diseased conditions can only be thoroughly studied when considerable quantities of it are carefully and frequently examined. Thus, while cellular pathology and the microscope have cleared up and rendered certain many dark and obscure diseased conditions—still we commence the search in the blood for a cause that will explain any diseased condition, handicapped—there are fields practically closed to research. We are not then surprised to find that the study of the blood in disease should fail so many times to give us any result. We are not surprised that in many diseases the blood has been set aside as a prominent factor; if the microscope can find no fault with the fluid, we pursue our researches in other directions. It is needless to rehearse the invaluable aid the microscope has been in pointing out with its powerful search-light the otherwise concealed homes of the disease-producing germs, but at the same time we believe there are things in the blood whose presence the microscope fails to reveal. If strychnia, opium and iron exert, as they do, marked influences upon the body through the blood and yield up their presence only to chemical agencies, we do not have far to go to believe that if we could obtain the blood in rheumatism as easily as we do the urine in diabetes and be able to subject it to as thorough an examination, we should obtain results as satisfactory. Were the blood as accessible as the urine, and could it be as frequently and thoroughly examined, our knowledge of it in disease would of necessity be greatly increased. We obtain from the urine a knowledge not only of the organs from which it is obtained, as in nephritis, but of profound sys-

temic disturbances, as well as in diabetes mellitus. The microscope reveals much, but chemistry more; the detection of the tube casts is no more valuable than the detection of sugar. The microscope and chemistry must go hand in hand before our knowledge is complete. One cannot fail to be impressed, in reading such a book as "Vaughan on Ptomaines and Leucomaines," with the powerful and subtle poisons which microscopic germs are capable of producing. That such poisons, only to be found by chemical influences brought to bear upon them, exist in the blood in many diseased conditions, there seems no room to doubt, and yet we know but little of them. The chemical difficulties in the way are truly great, as a perusal of the work just noted shows. Still, could the blood be readily obtained for examination and could we handle it with the ease and in the quantity we do the urine, the chemist would soon find for us simpler methods of search for these substances, which, while they wield an immense influence in the production of disease, are still the curiosities of the chemical laboratory. According to Hippocrates, the cause of fever was some morbid matter in the blood. In speaking of the various theories in regard to zymotic diseases, Watson says (p. 1087) "I have laid before you some attempts of able and thoughtful men to explain the main facts of the case; namely, the production of the disease by an animal poison; the prodigious increase in quantity of the specific virus within the body during the progress of the malady and the extinguishment of the susceptibility of its influence in that individual thereafter. Without adopting either theory with implicit credence in its truth, I hold my judgment in suspense until evidence more convincing shall appear, or until some better than either shall be propounded. If we turn from these quotations to that of Vaughan as embodying the belief of to-day, we find it a simple unfolding and rendering certain what was narrow and obscure. Vaughan says (p. 93), "An infectious disease arises when a specific pathogenic micro-organism, having gained admittance to the body and having found conditions favorable, grows and multiplies, in so doing elaborating a chemical poison which induces its characteristic effects."

Disease, as due to or indicated by the "buffy coat" disease; as shown by the changes in normal cells or the growth of new diseases as caused by or produced in some way through the influence of micro-organisms; are some of the most important paths which have led up to our present knowledge of disease. The blood itself, the cells, and now the many forms of bacteria, have been looked upon as able to solve for us that most vexed of all questions, the "cause of disease." As might have been supposed, no one of them has been capable of accounting for every diseased condition; and while each has added its quota, we well know how much is still unknown.

Without going further back than events within the memory of all present, we find great advances have been made, and probably no disease illustrates the advance more than diphtheria, as while the advance has been made, the future has still to reveal many of its secrets. The discovery of an adequate cause in a micro-organism makes us, as active physicians, rest with a feeling of comfort, unknown before, in our present mode of treatment, which gives our patients more comfort than they formerly enjoyed and prevents the spread of the disease, inasmuch as we know the life and habits of our enemies; we know the disease to be due, not to an invasion of the blood by the organism, but to an absorption from the seat of their growth and development of certain products of their life. This brings us to the new light which is to be thrown upon diseased conditions from another source, and it seems as though the blood must furnish it. The blood, whether drawn from the diseased body or from animals in the laboratory, would seem

about to take the place it had in the days of the "buffy-coat." In diphtheria, as in many other conditions, while it has not enabled us to cure, it has advanced us very far; and while we at present treat our patients with that confidence which knowledge only can give, we have great reason to believe that the future has more in store for us than the past.

Dr. B. W. Richardson speaks truly when he says "but when we come to precise facts, when we condescend to leave the true and fixed local diseases concentrated in the blood, great difficulties at once appear; because, after all, the blood, a constantly regenerated fluid, is but the channel through which diseased conditions, lying apart from itself, are temporarily presented. The blood may be the means of conducting or conveying into the tissues agents which may be poisonous, and so it may be itself poisoned from without. The blood may be the means, and is the means, of conveying poisonous products out of the body and of presenting them for oxidation and destruction to air, and so it may be poisoned from within. Both, however, of these states are but passing phases, and the same holds good in respect to all other conditions of diseases, with a few exceptions to the contrary, so rare they may be allowed to pass without special notice. The blood, in brief, is the whole body in transitory solution and is the representation of the body in that state."

The encouraging signs at present point to a something which shall supplement, or rather that our knowledge is to be carried a step further, and that more attention is to be given to the "products of bacterial growth . . . and albumoses of various kinds upon animal organisms." How much of value lies here the future only can unfold, but we hope, as we always do under such circumstances, for a great deal; and if nothing more is accomplished, we, in our daily endeavor to overcome our formidable antagonists, can pick up new courage in the belief that we are not at the end of our resources.

Dr. Billings, in his address at the opening of the new Laboratory of Hygiene in a sister city, says: "When however, a clue is once given to the student of causes, he may be able, by detecting differences in these causes, to call the attention of the pathologist to differences in results, and thus the bacteriologist, by proving specific differences in micro-organisms, all of which produce fever, suppuration, etc., induces closer study of details of cases by physicians and the recognition of new and more clearly defined groups of symptoms, and results, or, in other words, of new diseases." "Pathology and pathologic bacteriology are now waiting for increase of knowledge in organic chemistry." And again, "the recent advances in our knowledge as to the action of certain micro-organisms in the production of disease in animals and men have been largely made by laboratory methods and indicate clearly that the study of bacteria and of their development, products and effects, must be an essential part of the work of a hygienic laboratory, which should provide the peculiar arrangements and apparatus which are required for this sort of work. In fact, several so-called hygienic laboratories are simply bacteriologic laboratories, the interest in this particular branch of investigation having for the time being overshadowed all others. Our laboratory, however, must provide also for chemical investigations of air, water, food, sewage, secretions and excretions and the products of bacterial growth; for testing the effects of gases, alkaloids and albumoses of various kinds upon the animal organisms." Lastly he says "the hospital is filled with specimens of the results of such causes acting on the human body, from one point of view. Nature's experiments, with poisons cunningly elaborated in the tissues of the body or with viruses coming from without upon blood, and bone, muscle and brain. Much of the work of this new de-



partment will be connected with the results of these experiments." We have thus quoted from Dr. Billings as the most concise way of showing that, while the study of micro-organisms has not always helped us in the cure of disease, it has opened up a pathway which will be traced by the new laboratories, and from which we trust soon a road will be discovered that will lead us out of the present darkness. It has been well said that "the true rate of advance in medicine is not to be tested by the work of single men, but by what the country doctor is." We, as physicians of a practical age, have every reason to look for the time when every well educated physician shall be able to accomplish what the community in which he lives has a right to expect, namely: that he will be better able to cure and prevent their diseases than he is at present.

The blood, it seems, is to be a prominent factor in disease, and whether the poisons are carried by it or are formed within it, whether they are to be produced in the laboratories in media other than the blood, or are to be obtained from that fluid, the indications are that we shall not be able to kill the micro-organism as we had hoped to do, but must direct our efforts to the neutralization of their poisons through the blood. Much of the progress in the study of the blood in disease has been in the direction of diagnosis; this, while of value, has been of service only to those in hospitals. Thus the possibility, nay, almost certainty, of being able to find in anæmia not one, but several, different conditions; so that in patients presenting the symptoms of anæmia, a careful examination of the blood will enable the expert to distinguish between chlorosis, simple and pernicious anæmia. This power has not yet come into the hands of the general practitioner; nor has the ability to distinguish these different conditions been followed by an equal measure of certainty in treatment. The white corpuscles have in recent times attained a prominence and value in diseased conditions never known before, but here again, while the life and habits of the wandering cells are of value, we, as general laborers, and the "country doctors," have not yet been able to use them in diagnosis and treatment; they are too subtle for the ordinary means at our command.

From the study of the blood in hospitals and laboratories, light will come those outside in one of two ways; either all that is not essential will be sifted out and the means found necessary for diagnosis and treatment will be simplified, or new diseases, or modifications of old ones, having been found, they will cause him to look more closely at the symptoms presented by his patients. Thus, if the physician in private practice learns through the laboratories that anæmia may be due to one of several conditions, he will scrutinize his patient more closely and note the symptoms more carefully than if he believes anæmia due to but a single condition which is to be met with iron. We trust we may be pardoned if we have called to your attention familiar things, but the progress recently made in our knowledge of the blood through the microscope, and the possibility of its equally complete chemical study in the future, must be our excuse.

From the "buffy-coat" and its uncertainties we have come to the microscope and its certainties; and we can look forward in the hope that all this study of the blood in diseases is but the step which shall lead us to a certain application of medicines in the cure of diseases.

1010 Madison Avenue.

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The date of issue of the revised edition of the new Pharmacopœia cannot yet be definitely determined. The chairman of the committee on revision and publication states that it is hoped to have it issued during the current year.

## TWO CASES OF OVARIAN SARCOMA.†

BY L. E. NEALE, M. D., OF BALTIMORE.

CASE I.—Mrs. H., American, æt. 32 years; married, one child, health generally fair until one year ago; no family history of any malignant or tubercular disease. Menstruation previously normal, gradually diminished and suppressed during the past nine months, this being accompanied by abdominal discomfort, gradually developing into sensations of weight, pressure, and finally pain. Abdominal enlargement, starting from right iliac region, observed during latter five, and especially latter three months, but rapidly increasing during last one month, causing dyspnoea. There was no anasarca or œdema; urine normal, and no other pathological condition could be found, but an abdominal tumor rising from the pelvis to the umbilicus, surrounded by free ascites and offering a sensation of indistinct or uncertain fluctuation. Uterus retroverted. I examined the patient three times by the various methods, once alone, once in consultation with Professor G. W. Miltenberger, and finally in consultation with Professor W. T. Howard, each and every time all concurring in the diagnosis of *multilocular ovarian cystoma*, complicated by ascites, and all recommending early laparotomy. This was accordingly done, and after clear, straw-colored ascitic fluid escaped, the smooth, glistening, pearly blue wall of the tumor appeared and imparted to the directly palpating fingers the identical sensation of a tense, thin-walled cyst. Keith's trocar was then thrust in.

To avoid unpleasant details, which were really horrible to witness, the growths (for there were two, one overlying the other) proved to be a most malignant brain-like mass of round cell sarcoma growing from the region of the right ovary (which was totally destroyed), and surrounding pelvic soft parts. It was not practicable to secure a pedicle of healthy tissue, and after an operation of over one hour and a half in duration, the disease was but incompletely removed; a glass drainage tube used, and the patient put to bed pulseless and apparently moribund. Profound collapse; green vomit or regurgitation during first and second nights; tympanites; temperature 101° F., and under; pulse 110 to 120; drainage-tube discharging freely blood serum and bits of sarcoma. The tube undoubtedly saved her life for a time, for notwithstanding localized peritonitis (abdominal and pelvic), with small plaques of exudation, the patient recovered, and was up and about and even out of the house. The sloughing pedicles and redeveloping sarcoma, however, ultimately caused septicæmia, pyæmia, intestinal ulceration, perforation, and fecal discharge through the track of the drainage-tube, which had been removed on the fifth day. The patient died on the forty-second day after the operation. The post-mortem revealed localized peritonitis with adhesions, intestinal ulceration and perforation, communicating with the sinus left by the drainage-tube, making an intestino-abdominal fistula; rapid growth of sarcoma from the pedicles. The tumor was examined by Dr. William T. Councilman, who pronounced it "round cell sarcoma of the ovary."

CASE II.—Miss N. H., American, æt., 43 years, unmarried, never pregnant. Previous to September, 1890, general health excellent except scanty and occasionally irregular menstruation. At this time menstruation ceased, otherwise no disturbance whatsoever.

In April, 1891, complained of abdominal pain, especially in right iliac region, which persisted more or less constantly, and was at times severe. Health had re-

†Read before the Baltimore Medical Journal Club, December 12, 1891.

mained excellent, however; patient had not been examined and tumor was not suspected.

I saw her for the first time August 4th, 1891, and learned from her physician (Dr. Reeves, of St. Mary's Co., Md.) that, for the past two weeks only, her health had markedly failed, and the patient was rapidly breaking down, complaining of constipation, nausea, almost constant abdominal pain, often requiring repeated doses of  $\frac{1}{4}$  grain morphia. There was no history of any malignant disease in the patient's family.

Examination August 4th 1891 (Union Protestant Infirmary): Sallow, haggard, careworn, pulse 120, weak; temperature normal; nauseated, vomits occasionally, takes scarcely any nourishment, constipated for several days, sleeps poorly, looks and feels wretchedly.

Abdomen enlarged to about size and shape of a seven months' pregnancy. There is considerable ascites. No anasarca or œdema. Urine not examined. A large, smooth, even-walled tumor rises out of the pelvic cavity on the right side, almost filling the lower abdominal cavity to three inches above the umbilicus; thence to the left, and above too deep to trace.

Abdomen measures 38 inches at largest circumference just below umbilicus. Intestines distended; ascites free.

Vaginal examination reveals uterus retroverted and free, pelvic cavity normal, pedicle to tumor seeming to rise from right broad ligament.

No ovaries or adhesions could be felt even by rectal examination. The tumor felt like a tense cyst, and seemed to yield deep or indistinct fluctuation throughout. Diagnosis: *Cystoma ovarii dextri multilocularis*; ascites. Constipation could not be relieved despite the free use of sal. Rochelle and large enemata.

Patient required  $\frac{1}{4}$  grain of morphia hypodermically at night; she slept fairly well; vomited greenish matter in the morning and could retain nothing in her stomach. Pulse 110, weak, temperature normal.

Operation, August 5th, 1891, 10 A. M. Median incision, large quantity of *bloody* ascitic fluid escaped, bowels distended. Glistening thin walled tumor, veins coursing over it, rises out of pelvic brim on right side (ovarian?) thoroughly adherent to right lateral and posterior abdominal parietes, flush with under surface of liver (which could not be mapped out on account of tumor and adhesions), thence to left side, deep, adherent posteriorly and to diaphragm, with superimposed adherent intestines, distended colon crossing it above. Pelvic cavity clear. Tumor felt like cyst to touch.

Operation seriously complicated by distended and adherent intestines. Profuse bleeding, origin not found. Incision enlarged to seven inches. Trocar thrust into tumor and only dark venous blood escaped. Tumor soft and friable, broke under manipulation and large masses of sarcoma and clotted blood removed. Patient sinking, thought to be dying. Abdomen flushed with warm water, hæmorrhage partially checked, operation abandoned incomplete; duration, half an hour.

Abdominal incision closed, patient stimulated and put to bed almost pulseless; regained consciousness, spoke intelligently, never rallied, but sank and died six hours after the operation.

Post-mortem was not allowed. The following is the report on the examination of portions of tumor removed, made by Dr. J. W. Williams: "The masses of tissue removed consist of two distinct parts: an outer pale, smooth and glistening portion, which has the appearance of being malignant, and an inner, reddish, friable portion, which resembles blood-clot. At several places in the paler part of the growth are seen smooth surfaces which suggest cyst walls. Scrapings from

these surfaces show that they are covered with epithelial cells of all shapes and sizes, all of which exhibit marked fatty changes.

Frozen sections show the tissue to be distinctly sarcomatous, with here and there apparent patches of epithelial cells, some of which are immensely large and fatty. What appears as the blood-clot is really the same sort of tissue which has undergone degeneration, and into which there have been hæmorrhages.

Examination of hardened and stained sections.—Sections through the pale, solid part of the tumor show that it is a large cell sarcoma. Many of the cells are immensely large and contain several nuclei. In many of these cells, nuclear figures are seen, indicating rapid growth. It was these cells which appeared as epithelial cells on examination of frozen sections.

The internal, soft, reddish layer is composed of necrotic material, blood cells and fibrin and a very large number of leucocytes. This probably represents a primary necrosis of the internal part of the tumor, with subsequent hæmorrhage.

Diagnosis: Large cell sarcoma of the ovary, with necrosis and hæmorrhage into its internal parts.

*Remarks.*—Before proceeding to a consideration of these two cases, which constitute my personal experience with this disease, it is needless to say that, had I known beforehand all the conditions to be encountered, I should certainly have declined to operate in both instances.

The question of malignancy was considered and laid aside as questionable in both cases, but, even granting that it should have been positively confirmed, surely no one can conscientiously argue that this alone should exclude the hope of relief by laparotomy. The abdomen once opened and the exceedingly friable tumor once broken into, either by finger or trocar, what was to be done otherwise than what was done?

In a word, the point I make is, that the peculiar conditions or complications met with in both cases, which we could not detect beforehand, chiefly on account of a large quantity of ascites, would have deterred me from operating, but not the mere fact of the existence of sarcoma of the ovaries, even had that have been positively diagnosed.

Right or wrong, however, I am not without good precedent in this matter, as both Sims, Tate and others of that stamp have had experiences almost identical with my own.

*Frequency.*—The rarity of sarcoma of the ovary, as indeed, for that matter, of all solid ovarian tumors, seems to be sufficient justification for reporting these two cases. According to Greig Smith, only 3 per cent. of ovarian tumors are solid (Olshausen says 5 per cent.); being then generally malignant sarcomata or cancer.

*Character.*—In solid ovarian tumors malignancy is said to predominate in the proportion of 9 to 4.

Ovarian sarcoma has been stated to be either primary or secondary, congenital or acquired.

*Age.*—Youth predominates; out of 37 cases collected by Olshausen (Handbuch, d. Fr. Kn., Vol. II p. 685, 1886), five were under 20 years, nine in 20th year, 18 between 30 and 40 and only four between 58 and 67.

*Malignancy.*—After operating on 14 cases he states that the disease is usually not malignant, rarely has metastases, and is generally unilateral. The malignancy of the round cell variety is, however, scarcely questionable, as according to Beigel (Annual of Univ. Med. Sci., 1890) Baker Brown's case appears to be the only one cured by operation, and the disease runs a rapidly fatal course with

or without operation. It may in some cases remain inactive for an indefinite period and then rapidly develop.

*Bilateral.*—All of Olshausen's cases were double-sided and of 63 cases reported by Leopold at various times, 33 were bilateral. In neither of my cases could either ovary be found, both having been destroyed by the disease in each instance.

*Anatomical.*—These tumors may assume almost any shape and size. Goodell quotes Howell (Annual of Univ. Med. Sci., 1890), as giving the following description: "The ovarian sarcomata are not so irregular in their shape as the proliferating cystomata, being usually of oval or roundish contour; their surface is smooth, as a rule, and of a whitish or pinkish-white color; while in consistence they are generally, though not always, quite firm, the round cell variety being soft and brain-like." Both of my cases were of the latter consistence.

*Pathology.*—Sarcoma belongs to the desmoid and carcinoma or cancer to the epithelial group of tumors. The spindle cell sarcoma is most frequent, the round cell variety rarest. Transition stages to carcinoma: sarcoma carcinomatosum have been observed by Spiegelberg and others. These may contain hæmorrhagic extravasations, giving us the variety sarcoma carcinomatosum hæmorrhagicum. Hæmorrhage into an ovarian tumor renders its malignancy at least suspicious, and this condition existed in both of my cases. It was not diagnosed before operation, however, nor in the amount usually present do I know how it can be. Fatty degeneration, which is directly connected with the formation of cysts, is one of the most frequent metamorphoses of sarcoma.

Thromboses may develop in veins around fatty foci, giving rupture, hæmorrhage, peritonitis, etc., or emboli may occur with various complications, necrobiosis, sepsis and death by marasmus, hastened by ascites or metastasis. It is, however, rather to diagnosis than to pathology that I wish to direct attention.

*Diagnosis, frequency.*—The disease under consideration is confessedly hard to recognize. Its rarity may be one explanation of this fact, for although claimed by Leopold to be more frequent than is generally supposed, it cannot be denied that solid ovarian tumors are rare, occurring as I have already stated in from 3 (G. Smith) to 5 (Olshausen) per cent. of all cases of tumors of the ovary. Up to October 12, 1886, Professor Wm. T. Howard, of this city, had seen at least two cases and he stated (Trans. Balto. Gyn. and Obst. Soc., October 12, 1886), that the late Dr. William L. Atlee had not seen one out of 378 ovariectomies. At that writing Sir Spencer Wells had seen only three cases out of 1,000 ovariectomies, and Dr. Thomas Keith had seen none. Dr. Wm. Goodell (Pepper's System of Medicine, 1886, Vol. IV, p. 299), gives the following diagnostic marks of malignant disease of the ovaries:

*Signs and Symptoms.*—(a) "The presence of ascitic fluid or of œdema of the lower extremities when the tumor is too small to produce such pressure symptoms.

(b) General cachexia, rapid emaciation, and grave constitutional disturbance out of all proportion to the size of the tumor.

(c) The hardness and the solidity of the tumor, together with its nodulous and irregular surface.

(d) The concurrent development of two ovarian growths.

(e) The retraction and burying of the cervix in the vaginal vault.

(f) Pain in stabs, starting from the groin and running down the inside of the thigh. But pain is not a trustworthy symptom, as it is often absent, especially in cysto-carcinoma and may be caused by benign growths as well."

To this catalogue of symptoms might be added pleuritic and other serous effusions which are sometimes observed in these cases.

Both of my cases exhibited marked rapidly accumulating ascites in anæmic cachectic patients, but no œdema.

It is generally admitted that malignancy should always be suspected when a solid ovarian tumor is found, which, being of moderate size, causes ascites and anasarca of the limbs, not due to discoverable organic disease, especially when this condition is associated with emaciation and cachexia, which begins slowly and then progresses rapidly.

These are at best, however, only fair grounds for the suspicion of the malignancy, but by no means positive evidence, for it is not at all uncommon to see an essentially similar if not identically the same clinical picture in cases where the disease is perfectly benign, as has been my experience in more than one instance. Moreover, my patients were not long under observation; the rapidity of the development of ascites, cachexia etc., could not be accurately ascertained; there was no œdema of the limbs, and in both cases the tumor was thought to be cystic, not solid. Before the Obstetrical Society of New York, January 4th, 1887, (Transactions in American Journal Obstetrics, Volume XX, page 173), Dr. Coe reported a case of sarcoma of the ovary with well marked ascites and anasarca of the lower extremities, the cause of which was obscure, but was found to be due to the pressure on the vena cava inferior by a diseased and displaced kidney. The case illustrated the necessity of eliminating every possible source of venous obstruction before attributing the ascitis and anasarca to the tumor. At the same meeting Dr. Polk reported a case of well marked and rapidly occurring ascites from the fluid that had escaped from a ruptured ovarian cyst.

In ascites due to malignant disease, laparotomy is considered preferable to tapping (Lee, etc.). Diagnostic tapping is considered bad practice; malignant diseases often spread with greater rapidity after it and the immediate dangers from traumatism, hæmorrhage, &c., are generally admitted.

No elements found in the ascitic fluid can be regarded as positive evidence of the malignancy of an abdominal tumor. I might incidentally mention that after a study of this subject (Goodell in Annual Universal Medical Science, 1888, p. 77 et seq.) "M. Quenn concludes that ascites is rare in uterine tumors, whatever their nature, frequent in solid ovarian tumors, and is the rule in papillomatous cysts, the fluid in these cases being secreted directly from the vegetations."

"According to Dr. Larabrie the density of ovarian fluid is greater than that of ascites, 1.010 to 1.015 in the former to 1.018 to 1.024 in the latter."

Again, "Waldeyer has shown that in ovarian cystic fluid paralbumen is present and never in ascitic fluid." But if paralbumen be present it "does not necessarily prove that the fluid is ovarian, since Schetelig has found this albuminoid in a tumor of the kidney."

*Adhesions.*—To return to the two cases under consideration, I will state that the adhesions met with is not the rule in malignant disease of the ovary on account of the early setting in of ascites. Thus, "we know that the presence of fluid, ascitic fluid, saline solutions, etc., in the abdominal cavity helps to prevent adhesive inflammation by keeping the tumor away from the loops of intestines," and possibly by exerting some influence on the capillary system by osmosis.

*Softness.*—But the most misleading condition in my cases was the peculiar cyst-like sensation imparted by the encephaloid sarcomatous masses.

In further illustration, I recall the case of Captain J. M., who died of round-cell sarcoma of the left kidney and upon whom I made the post-mortem. The abdomen was widely opened by the long crucial incision, the tumor thoroughly exposed and carefully examined, and so sure was Professor Tiffany that it contained

fluid (hydronephrosis), and was not solid, that he held a bucket against the tumor before requesting me to incise it. Much to our surprise, only a little dark blood escaped and the friable mass readily broke down under further manipulation. The most expert diagnosticians have been misled by this sensation, and although I have devoted considerable attention to the practical study of palpation it has already deceived me three times and I fear my experience may be repeated. In the cases herein narrated it deceived us all, both before and during the operation, after the abdomen was opened.

*Difficulty of diagnosis.*—The limits of this paper will not permit me to discuss all the points bearing on the diagnosis of ovarian sarcoma, but in brief I may say that there is no sign or symptom and no group of signs or symptoms that can be regarded as pathognomonic. Indeed, Greig Smith declares that "solid tumors of the ovary cannot be diagnosed from each other, and with great difficulty from similar growths arising from the uterus."

Ascites, œdema, anæmia, cachexia, suppressio mensium, pain, and even the physical characteristics of the tumor and the surrounding structures, have misled the most expert diagnosticians. The best authorities admit that the diagnosis of round cell sarcoma of the ovary, or for that matter any form of ovarian sarcoma, is exceedingly difficult, and in some cases, under certain conditions, absolutely impossible. In my cases I do not claim that a diagnosis was impossible, but, as the facts prove, it was too difficult for us to make.

*Justifiability of operation.*—I must again, however, insist upon the point already made that malignancy is "no longer regarded as a contra-indication to ovariectomy when the disease is limited to the ovary." When it involves other organs the operation is considered justifiable only under very exceptional circumstances, when insupportable suffering is to be relieved thereby. Freund, however, who has had exceptionally good results in this class of cases, includes even disseminated growths as coming properly under the class to be operated on, and proves that individuals suffering from diffused malignant growths may continue to live and thrive after complete removal of the same. Even in the case of carcinoma "he declares that while it remains local, with no infection of the lymphatic or circulatory apparatus, and when not interfering with the function of any important organ, the surgeon should follow it relentlessly into almost every organ of the body (Obs. f. Weitsch. f. Geb. and Gyn., XVII, 1)."

*Time of Election.*—Had the cases above reported been seen and operated upon earlier, before such development and complication of the tumors occurred as practically defeated the aims of the operation, I am of the opinion the result might have been different.

Upon this point, in answer to the question, "When does an ovarian tumor call for interference?" Dr. Karl Sandberg (Gyn. Soc. Chicago, Sept. 27th, 1889, VI, Amer. Jour. Obs., Vol. XXIII, p. 540), says: "I think it is agreed that it is bad practice to wait until the patient's health is affected or her life threatened (W. H. Byford); until she is failing in strength, and becoming emaciated, depraved and nervous (T. G. Thomas); until she is seriously distressed and her health and activity impaired (P. F. Mundé); until sharp abdominal pains lead to the suspicion of localized peritonitis and adhesions (P. F. Mundé); until the belly is distended and the woman has become thin and her health has begun to fail (Goodell); until the tumor has reached the umbilicus (Hegar, Kaltenbach); until it is beginning in any way physically, or mentally, to do harm, or until the woman has become accustomed to the confinement of a sick-room and has lost flesh (Spencer Wells.)"

He adds: "None of these conditions are required for any other operation, and they are only reminiscences of the time when ovariectomy was considered preferable only to immediate death. The sooner we throw them overboard the better. An ovarian tumor always calls for interference, and it calls loud enough to make additional indications unnecessary."

319 W. Monument St.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAR. 4, 1892.

The 263rd regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

*Dr. Herbert Harlan* spoke of a case of BUPHTHALMOS which had recently come under his care. Buphthalmos is simply a very large eye. It is very rare; in over 56,000 cases at the Presbyterian Eye and Ear Hospital, not one case of buphthalmos has been recorded. There are some cases put down as bulging of cornea, and probably one or two of them were cases of congenital buphthalmos. Dr. Harlan's case is a girl of 11 years, with both eyes affected, but one larger than the other. The condition was noticed at birth; eyes gradually grew worse. Sight was never good; in one eye the cornea became completely opaque; there was a good deal of inflammation and pain for six months and then all light perception was lost. The other eye has likewise been somewhat painful; it is enormously enlarged, almost as big as the eye of an ox. Cornea of usual thickness, tension about normal, iris a little thin and apparently a little stretched about outer margin. Eye exceedingly myopic. It looked like any other eye except its enormous size. Quite a number of cases of enlarged eyes are reported, but they are not perfect like this one. Dr. Harlan saw another similar case recently in a negro man, but the eye was defective. It was  $1\frac{1}{2} \times 1\frac{3}{4}$  inches in diameter. The eye was removed. Vitreous and lens opaque, cornea cloudy, and ciliary region inflamed.

*Dr. Robert Randolph:* I found, about a year ago, in a bottle at the Eye and Ear Hospital, a buphthalmic eye. It was evidently taken from a child 6 or 8 years ago. There was a marked cylinder-shaped excavation of the optic nerve very much as we see in glaucoma. The eye was thin; it was full of holes, showing that it was much atrophied. The ciliary body was atrophied, cornea cloudy.

I think Nettleship reports a case in which iridectomy has done good. I understand that there is a case in France where the vitreous is systematically drained.

*Dr. Chambers:* Was the rest of the face symmetrical in Dr. Harlan's case?

*Dr. Harlan:* She is a very pretty little girl.

*Dr. Randolph:* Is it not generally one-sided?

*Dr. Harlan:* It was double in both cases of mine, but one eye larger than the other.

In these two cases I looked at the optic nerve and there was no depression. I think it likely that the one Dr. Randolph found was one of secondary glaucoma.

*Dr. Randolph:* It was one of hydro-ophthalmos in a child.

*Dr. J. L. Ingle* reported a CASE OF OSTEOMYELITIS in which the symptoms during life were so misleading that the real nature of the disease was only discovered at the autopsy. A healthy boy of 14 years was for several days less viva-



cious than usual, then on November 20th, 1891, was taken seriously sick. Previous to the 20th there had been a festered spot on left ankle which had apparently healed. On the 20th, fever  $104^{\circ}$ , with severe pain in left leg from the knee to the toes. Fever high till 22nd, when it fell to normal. On this day had some epistaxis and on the following day tympanitis marked. Acute rheumatism was diagnosed and salicylate of soda given. Mind wandered from the first. Constant headache from beginning to end, with persistent insomnia. On the 23rd Dr. Earle suspected typhoid fever from delirium and epistaxis. Dr. Ingle was inclined to regard it as a case of cerebral meningitis. The child lay with both eyes closed, was irritable when aroused, avoided light, was constipated, surface pallid, erythematous blushing, dilated pupils. Instead of a retracted abdomen there was an enormously distended one. At this time there was marked soreness all over the body. Patient put upon iodine and bromide of soda, but no benefit derived. Tympanitis increased and interfered with respiration and circulation. The child died and an autopsy was made by Dr. Chambers.

*Dr. J. W. Chambers:* The meninges of brain were markedly congested and there was just such a condition as one would expect as the result of sepsis. There had been seemingly no definite cause for sepsis. The sore on the leg had scabbed over and was dry. Looking over the extremity it was observed that his leg over the tibia was enlarged and œdematous and this caused us to cut down. The periosteum was œdematous and red and easily detached. When ripped away, quite a large amount of bloody pus oozed from the centre of the tibia. No other bones were allowed to be examined, although from the fact that he had had pain in the other leg and elsewhere in the body we suspected that it was a case of multiple osteomyelitis involving several bones.

As an idiopathic disease osteomyelitis has not received much attention until within the past few years. The cause of the disease is probably simply the pus microbe getting into this particular locality. It is probably always secondary to some pus formation elsewhere in the body. Some think it is absorbed from the alimentary tract, the bronchial mucous membrane or other sources, and then finds its way into the bones—mostly young bones near the epiphyses. The disease is often difficult to diagnose. Holmes has said that a large number of these cases are diagnosed on the autopsy table. We have few definite symptoms to guide us. I do not think any doctor should feel very much chagrined if he should fail to diagnose osteomyelitis in such a case as the present one. It is probable that many cases die under our care that we have diagnosed as something else. I have seen but three: two I recognized at once, the third only after the death of child. The only distinctive symptom was intense pain at one point. By pressing over the bone, if the individual is not thoroughly affected by the septic condition, you can find tenderness. The prognosis is bad. Multiple cases are very little modified by medical or surgical treatment. Where only one bone is involved if we recognize it or suspect it I should not hesitate to trephine. We can in this way save a number of lives or a good deal of destruction of tissue. I would not have any more hesitation in boring into a pus cavity in bone than in opening an abscess in the soft tissue. In multiple cases the sepsis is so great that there is scarcely anything to be done either by surgeon or physician. Under these circumstances I would not hesitate to give relief to tension.

*Dr. W. S. Thayer:* I saw, some three years ago, at the Massachusetts General Hospital, a case very similar to the one reported, except that the bone was the femur. A boy of 14 was admitted to the medical side with a diagnosis of sciatica. He had been treated by a reputable physician for ten days with this diagnosis.

For a week before entrance had had occasional chilly sensations, but no actual chill. He was in a typhoid condition, dry brown tongue and high fever. I found upon examination that the upper part of the thigh on one side was distinctly larger than that on the other side, somewhat tense to feel and rather hot. He was immediately transferred to the surgical side, an opening was made and a large quantity of pus was found. The boy was in a state of septicæmia from which he did not recover.

*Dr. S. T. Earle* reviewed the literature of osteomyelitis with especial reference to causation.

*Dr. J. M. T. Finney*: This disease in a certain number of cases is difficult to diagnose; in certain other cases it is not. I happen to have seen two or three of the latter class. As far as the pathology is concerned, I think it is simply a bone abscess. The treatment is like the treatment of a like condition in other tissues, viz: where there is pus, evacuate it. The resemblance of this disease to appendicitis is very marked. It gets well in many cases and will return again. As we are coming more and more to operate in appendicitis so we ought more and more to operate in myelitis. There is one point in diagnosis which *Dr. Chambers* has not referred to and which seems to me a most important one, viz: local œdema. Local œdema seems to me to be the most characteristic sign of pus deeply seated.

*Dr. Finney* related three cases operated upon by himself, all making good recovery. The staphylococcus pyogenes aureus was found present in all these cases.

*Dr. Chambers*: As to œdema, a good many cases may die from sepsis before œdema is present. If you get pain and œdema then the diagnosis is more sure.

*Dr. S. T. Earle*: I saw the case reported in the early stage. There was no point of localized tenderness. He was tender from the knee down, with no point worse than another. In about two days after the onset there was just as much tenderness over the right limb as over the left and this hyperæsthetic condition soon became general. As to œdema, the limb was only a trifle larger in the whole extent from the knee down.

*Dr. J. M. T. Finney* then read an exhaustive paper on APPENDICITIS.

*Dr. W. S. Thayer*: A number of men in Munich have collected 1,000 cases of appendicitis in the Munich hospitals. A German doctor has analyzed these cases and arrives at the conclusion that appendicitis is fully as common in females as in males, if, indeed, it is not more common. As to age, he finds the proportion almost exactly the same in old age as in youth.

The operation must be governed by surroundings. In a large city where we have good surgical skill, I believe that where the symptoms progress 24 hours the case should be handed over to the surgeon. I believe the majority of these cases belong to the surgeon.

*Dr. J. D. Blake*: There is no doubt but that under proper conditions an early operation is advisable. To induce the patient's family to permit the operation to be done at his home or at a hospital is often impossible.

I was rather struck with *Dr. Finney's* idea of combining all these conditions—typhlitis, perityphlitis and appendicitis—under the same head, because it is a difficult thing to know just which you have.

I remember that *Dr. Chew* once said that at a meeting of the American Medical Association, the physicians were discussing appendicitis on the medical side and concluded at a very early day such cases should be handed over to the surgeon for operation; at the same time the surgical section were discussing the same thing and concluded that an operation should not be performed too early; that it was better to wait.

I have seen two cases where an early operation showed that the trouble was located in the appendix, which was removed. In two other cases that I have seen there was so much adhesion that it was difficult to determine where the trouble began.

I remember one case, in a young man, where the aspirator was used to determine the presence of pus. Three and one-half ounces of pus, with distinct odor, was drawn. It was thought better not to withdraw it all as the walls of the abscess might collapse and there would be a tear into the abdominal cavity. The patient has since had no further trouble. Eight months ago I was called to a young man with appendicitis. I advised operation, which was declined. Five days later I aspirated him and drew away nearly four ounces of pus. The next day I drew away a little over two ounces of pus. On the 10th day I removed about an ounce of very thick tenacious pus. I had a similar case six months ago in which I aspirated twice. He has since complained of pain about that region and I have recommended an operation. Certainly where the diagnosis is not plain an aspirator rarely jeopardizes the case and very often throws some light upon the trouble. In another case in which I used an aspirator, I got three ounces of blood and the symptoms all disappeared.

*Dr. J. F. Martenet:* I am distinctly a medical man, but I have been converted through personal experience to the belief that appendicitis is distinctly a surgical trouble. The cases which I have attended have come on abruptly with acute pain. I have had four cases in my practice within twelve months. Two of the cases Dr. Chambers saw with me. An operation was advised, but in neither of the cases would the family consent. My habit at present in every case I meet with is to state that it is a distinctly surgical trouble and refer it to the surgeon. One of my cases who refused operation secured relief by suppuration through the bowel. This was a year ago. In July last she passed through another attack safely. Lately she was operated upon by Prof. Kelly and is now well.

*Dr. J. W. Chambers:* The statistics from the medical side seem to be faulty. A person may have three or four attacks and they are reported as four cases cured. A surgeon operates on a case and reports one case cured.

As to women having it as frequently as men—I have under my own observation known of three women upon whom the gynæcologist had diagnosed pelvic cellulitis and salpingitis, and removed the "tube" which proved to be the appendix. In a large number of cases the appendix is really a pelvic organ, and if inflamed it will certainly be a case of salpingitis with some gynæcologists. Such errors may have something to do with statistics. There is no reason in the world why women should escape more than men; certainly they are just as liable to catarrhal affections.

Referring to aspiration, I think Dr. Blake's patients are relieved rather than cured. I should hesitate to use the needle. If I should find pus with the aspirator I should never feel that I had done my duty unless I had cut down and removed all the pus. It would not be good treatment to aspirate an abscess of the thigh and it is also not good treatment for an abscess in the iliac region.

*Dr. Ingle:* I believe the sooner we place these cases in the hands of the surgeon, the better. When the family would not consent to an operation, I have treated these cases with salines and enemata without any relief whatever.

*Dr. Thayer:* In the Munich statistics it was said that undoubtedly cases of appendicitis had been called salpingitis and pelvic cellulitis and many cases in the female were doubtless missed in this way.

*Dr. Martenet:* Two of my cases occurred in females, one of five years, the other of ten years of age.

*Dr. Blake:* There are certain cases where I can find no distinct indication of what my patient has, whether it is typhlitis, perityphlitis or appendicitis, and when I have waited long enough I put in an aspirator to find out if there is pus and in no case have I seen bad symptoms follow, and in some there was distinct benefit. I think we are thoroughly justified in using an aspirator to make a diagnosis.

*Dr. Finney:* As these are pus cases the operation can be done as well at the patient's home as in a hospital.

As to aspiration: I agree entirely with Dr. Chambers. Where there are sufficient indications for aspiration there are still more indications for the use of the knife.

1603 N. Broadway.

W. T. WATSON, M. D., Secretary.

#### CHICAGO PHYSICIANS AND THE HEALTH BOARD.

A correspondent of the *Medical News*, March 19, 1892, writes:

Charges of professional discourtesy, arbitrary conduct, and officiousness, were preferred against our City Health Commissioner at a recent meeting of the Chicago Medical Society. The charges were embodied in a petition that had been circulated among the members of the local medical profession asking for an investigation into the methods employed by the Health Department relative to reporting contagious and infectious diseases.

In the early part of February last, Commissioner Ware sent to all physicians postal cards requesting them to report to the Health Offices all cases of typhoid fever coming under their care, as the report was of vital importance as a matter of record. The card also stated that premises would not be placarded for typhoid fever. A week after he received a letter from a prominent physician to the effect that he would make no such a report, unless he received positive assurance of being paid for such services rendered to the Health Office. He was opposed to the ordinances that compel a physician to report contagious cases to the Health Office. He considers the law unfair in this regard. What right has the city to ask a physician to do its work for nothing? In England they do things better. They give a physician a fee for reporting cases of contagious disease. The fact is, said this prominent physician, the methods employed by our health and sanitary departments are wrong. The law that places a placard quarantining a house in which is a contagious disease is a relic of barbarism, a practice of mediæval times, and it does a great wrong many times. Take the case where the placard is nailed on the door of a man who has a small shop under his living rooms. That man's business is ruined for two months at least. Now, is it fair or right that he should suffer simply because there is some danger that the contagion will spread beyond his house? Nothing can be done toward properly quarantining people until a contagious hospital is built.

The latest nickel-in-the-slot machine doles out quinine. It will be welcomed warmly by the myriad of victims of that abnormal linguistic adaptability of the drug clerk that enables him to match his "quynyne" to their "queeneen," and *vice versa*, to the invariable displacement of their psychical equilibrium.

During the last ten years seventeen women have passed the qualifying examination at the University of Brussels and obtained the license to practice as pharmacists; sixteen of them are now actively engaged in the pursuit of that profession.—*Bulletin of Pharmacy.*

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**THE MARYLAND MEDICAL JOURNAL.**

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

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BALTIMORE, APRIL 9, 1892.

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### **Editorial.**

#### A DANISH EFFORT TO PROVIDE PURE MILK.

An extensive notice is presented in the U. S. Consular Report, December, 1891, concerning this important subject. It seems that a prominent business man of Copenhagen, some years ago, became impressed by the inability of his employees to secure wholesome milk for their families, and organized a company for meeting this need. The enterprise began on a small scale, with a capital of \$3,000, and has developed into a large and remunerative business.

The only milk accepted is that which is supplied from farms which have a really superior and healthy stock of cattle; and, besides this, the company demand from farmers and managers a written guarantee that its rules respecting the feeding and treatment of the cows shall be strictly attended to.

The price paid for the milk is the very highest obtainable, higher than the parties contracting can get for it anywhere else; thus the contractor would suffer a pecuniary loss were his contract to be cancelled, and he has the highest inducement to comply with the regulations of the company.

A specialty of the company is milk for children. Special attention is paid to the winter fodder of cows yielding this supply. In summer all cows are fed alike; their fodder must be grass and clover only; they must on no account be kept in the house during the summer. In the winter those giving children's milk must be fed only with hay, straw, oats, barley, wheaten bran and a small quantity of carrots.

The milk of cows newly calved must not be supplied until twelve days after calving.

Particular attention is paid to the examination, at short intervals, for tuberculosis, as it is believed that the development of tuberculosis of the udder is in certain cases so rapid that an early diagnosis of tubercular disease in any situation is imperative in order to avoid the great danger that would arise from mixing with sound milk the milk of cows so affected.

All milk is passed through gravel filters. The milk carts are so constructed that there can be no tampering with any of the cans. Every can and every van door is sealed. In all cases the cans are surrounded by ice in hot weather, so that every precaution is taken that the milk shall reach the consumer in good sound condition. Every milkman is in uniform, and every cart and van has the trademark of the association—a red and white clover blossom with green leaf on a black triangle painted on a pink ground.

All cows are examined by a competent staff of veterinary surgeons once a fortnight.

The veterinary surgeon must fill up a form, in which he gives a report on the condition of the fodder and on the state of cleanliness in which both cows and cow houses are kept.

Any cases of lung complaints, or of other diseases, real or suspected, he must report, specifying more particularly which of the animals supply milk for general and which for special uses. He is also obliged to state how much milk is yielded by the cows which are ill and separated from the others, and the use made of it.

As a further precaution, an inspector is regularly sent out to examine the management of the dairy farms. He must fill up a form, reporting on the condition of the cows and the quality of the fodder; he must also see that the rules laid down by the company are observed with regard to feeding the animals; also that cleanliness is exercised while milking.

He must examine the cooling apparatus; report if it is in order; if there is a sufficient stock of ice; and how it is stored. Besides all this, an experienced dairy-maid is sent out to superintend the milking of the cows. Her attention is especially directed toward securing cleanliness during the milking; also to the cooling of the new milk. In order to keep the milk as cool as possible after the arrival at the company's dairy, the milk cans are placed in large tanks filled with ice; but before this is done the milk undergoes a thorough process of purification.

At first only milk intended for children was subject to the system of filtration, but since it has been proved to be so advantageous, all the milk and cream sold by the company are now filtered. When the milk is in the dairy, every care is taken to preserve its purity.

Through the partition wall dividing the filtering apartment the milk is conveyed by means of pipes into another hall, where it is bottled, the workmen employed in the process of bottling being supplied with clean white blouses, caps, and aprons.

Every contractor is pledged to report immediately on any case of infectious disease appearing either upon his farm or among his work people. His attention is especially directed to the women who milk, no one in whose home an infectious disease has broken out being allowed to assist in dairy work.

To ensure the contractor against loss in cases of this kind, the company is bound to purchase the suspected milk at the usual price, but only if intimation as regards the outbreak of the disease has been made at once.

The milk is not resold, nor does it ever come in contact with the milk which the company supplies to its customers.

In addition to the direct advantage received by those who buy the milk of this particular company, there is an indirect advantage which is even greater. By teaching the people of the city what really good and wholesome milk is like, the whole milk trade has been roused to the necessity of supplying a good article.

So important is this trade that the apothecaries undertake the distribution of the pure children's milk, specially on Sunday, when the other shops are compulsorily closed.

It even strikes at the problem of caring for the destitute; for charitable societies purchase milk tickets in thousands at the dairy, enabling the holders to get the purest and most wholesome milk in the country at the same price that it costs the company itself to obtain it. Those tickets are not distributed gratis, but sold to persons of small means at so low a figure that *even milk of the most inferior quality cannot be had for less*. This is an admirable form of charity, and unquestionably secures incalculable benefits for the very poor.

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#### THE MEDICAL LAW.

We are informed that the Bill to Regulate the Practice of Medicine in Maryland, given in full in our issue of March 26th, has become a law.

This law practically confirms the Medical and Chirurgical Faculty of Maryland in its ancient authority as a licensing body. Not in its original extent—for all practitioners; but in a limited degree—for all future practitioners except Homœopaths.

The promoters of the Bill deserve the thanks of the medical profession of the State and of the whole country.

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#### THE "BUFFY COAT."

It seems strange to see this term in an article of the present day, not historical; yet the plea put forth by Dr. Smith, in our "Original Article" column, for the importance of the blood as a fluid tissue in disease-changes, will appeal to many thoughtful readers.

By-and-by the pendulum of research will swing back from the microscopic study of the cells to the chemical and physical study of the fluids of the body.

Not believing that the microscope is to be the final diagnostic agent in general practice, we sympathize deeply with the family physician who, born into medicine before the "germ-era," still clings to the belief that there was profound thought and practical learning in the medical world before the present decade began.

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#### EDITORIAL NOTE.

Repeated requests have been received for copies of the JOURNAL containing the article on "Plaster-of-Paris Jackets" by C. C. Barnwell. As we are unable to supply such demands, owing to the exhaustion of that issue of the JOURNAL, we

would refer applicants to the author, 407 W. Hoffman St., who will furnish neat reprints of the article at the price of twenty-five cents each.

### Reviews, Books and Pamphlets.

*A Manual of Diseases of the Nervous System.* By W. R. GOWERS, M. D., F. R. C. P., F. R. S., Consulting Physician to University College Hospital; Physician to the National Hospital for the Paralyzed and Epileptic, of London. Second edition. Revised and enlarged. Vol. I; Disease of the Nerves and Spinal Cord, with 180 illustrations. Philadelphia, P. Blackiston, Son & Co., 1892. Price \$3.50.

To those skilled in diseases of the nervous system we need only mention the fact that the first volume of the revised edition of this standard work has appeared and that the second volume will soon be ready. The volume before us, in addition to general revision to bring it up to date, presents new sections (50 pages), on multiple neuritis, and also new articles on beri beri, brachial neuritis, senile paraplegia, Morvan's disease, and the peroneal type of muscular atrophy.

The department of diseases of the nervous system is probably the most difficult of all branches of medical study, and among practical branches it is one of which the average physician is most ignorant. Dr. Gowers' work is a good book of reference for the physician's library. It is clearly written and well illustrated, and will guide him to the proper understanding and treatment of many a patients' case now neglected and obscure.

*Diseases of the Bladder and Prostate.* Physician's Leisure Library Series. By HAL C. WYMAN, M. Sc., M. D., Professor of Surgery in the Michigan College of Medicine and Surgery, Detroit, 1891. George S. Davis, Detroit Mich. Price 25 cents.

Of the 130 pages, in neat type, 110 are devoted to wounds and diseases of the bladder, and operations upon it; while the remaining 20 pages are given to diseases of and operations upon the prostate. Its teachings are throughout enforced and enlivened by the author's personal views and criticisms. An index is appended.

### Medical Progress.

#### NASAL HYDRORRHOEA; CAUSED BY POLYPI IN THE ANTRUM.

At a recent meeting of the Nottingham Medical Society, Dr. A. R. Anderson, (*British Medical Journal*, February 6, 1892,) related the case of a girl, aged 19, who had for some time been troubled with a perfectly clear watery discharge from the left nostril. The discharge was almost continuous, but could be increased by inclination of the head to the opposite side, and, after a quantity had flowed forth in this way, it would for a time cease. From the symptoms, it appeared evident that the antrum furnished the discharge. The molar teeth on the affected side were carious, and the cavity was opened by extracting the second and perforating the bone, when a quantity of clear fluid, similar to that discharged from the nose, was evacuated. The cavity was drained into the mouth, and douched daily with astringent wash. This did not effect a cure, so the opening in the bone was enlarged to a sufficient extent to admit the end of the little finger, when a number of minute polypi were found projecting from the mucous lining of the antrum. The interior was scraped with a director, and swabbed



out with a solution of chloride of zinc, which effected a cure in about six weeks. When last seen, some months after, the patient was quite well and had no recurrence of the symptoms. Allusion was made to a case very similar to the above in many respects, which had been reported by Sir James Paget to the Clinical Society in 1879.

#### TREATMENT OF STRICTURE BY DIET.

In a recent discussion (*Atlanta Med. and Surg. Journal*, March, 1892), Dr. Bedford Brown said: My preceptor, Dr. B. W. Dudley, of Lexington, Kentucky, in whose office I spent three years, treated stricture alone by diet and medicine. I saw his cases; I studied them, I analyzed them, and I know cases would come to him in which the sound would pass with the greatest difficulty, but after treatment the sound would enter the bladder without difficulty, and they would have no more trouble. His method was peculiar. He told me, and spoke of it in his lectures in the Transylvania University, that in his younger days a case of typhoid fever came under his charge, in which case there was a bad condition of stricture, one of the worst he had ever seen. The man was down with typhoid fever for three months; when herecovered from the fever the stricture was gone. The man was reduced to a skeleton. Dr. Dudley was a man of remarkable powers of observation and took his lesson from that case. From that time forward he treated strictures by diet in reducing the system and medicine with success, and I assure you I have seen him do it time and time again.

#### THE SWEDISH CURE FOR DRUNKENNESS.

The habitual drunkard in Norway or Sweden renders himself liable to imprisonment for his love of strong drink, and during his incarceration ne is required to submit to a plan of treatment for the cure of his failing which is said to produce marvelous results. The plan consists in making the delinquent subsist entirely on bread and wine. The bread is steeped in a bowel of wine for an hour or more before the meal is served. The first day the habitual toper takes his food in this shape without repugnance; the second day he finds it less agreeable to his palate; finally he positively loathes the sight of it. Experience shows that a period of from eight to ten days of this regimen is generally more than sufficient to make a man evince the greatest aversion to anything in the shape of wine. Many men after their incarceration become total abstainers.—*Health and Home.*

#### VENTILATION BY PERFORATED WINDOW-PANES.

A Paris correspondent of the *British Medical Journal*, March 12, 1892, writes: Appert's glass manufactory, where Professor Marten has lately been lecturing on hygiene, is a model of sanitation. Glass blowing is no longer done by the mouth, but by compressed air. Lead mixing is done by workmen wearing a mask in which are inserted sponges on a level with the nose and mouth. It is in this manufactory that the glass panes perforated in conical-shaped apertures to admit the air are made. This form of ventilation is due to M. Emile Trélat. The apex of the cone is outermost, the air thus passing through an opening larger within than without, and in this way is diffused without causing a draught.

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### Medical Items.

We regret to learn that by the Friedenwald fire which occurred recently, 500 copies or one-half of the edition of Dr. E. F. Cordell's "Historical Sketch of the University of Maryland" were destroyed,

The Jefferson Medical College of Philadelphia is to have a handsome hospital lecture hall and laboratory building. The buildings will cost \$500,000.

Dr. C. W. Hartwig has been appointed the resident physician of the Presbyterian Eye, Ear and Throat Charity Hospital for the ensuing year, from April 1st, 1892.

Cincinnati will be honored by having the State Medical Society meet there in the early part of May. The programme is an excellent one, and everything points to a very large attendance from all over the State.

The 41st Annual Session of the Iowa State Medical Society will meet at Des Moines, Iowa on May 18th, 19th and 20th. A large and interesting program has been issued. Further information may be obtained from Dr. L. Schooler, of Des Moines, Chairman of the Committee on Arrangements, or Dr. Cokenower, of Des Moines, Secretary.

The Belgian Society of Gynæcology and Obstetrics, under the patronage of the Belgian Government, has taken the initiative in organizing "The International Periodical Congress of Gynæcology and Obstetrics," the first session of which will be held in Brussels, September 14 to 19 inclusive, 1892. Three leading questions will be offered for discussion: 1st, Pelvic Suppurations; referee, Dr. Paul Segond, Paris; 2nd, Extra-Uterine Pregnancy; referee, Dr. A. Martin, Berlin; 3rd, Placenta Prævia; referee, Dr. Berry Hart, Edinburg. Fees; members participating in first session, 30 francs. (This will entitle the holder to a copy of the proceedings of the Congress.) Founders (Life Membership), 300 francs. In connection with the Congress there will be an International Exposition of Instruments and Appliances, pertaining to Gynæcology and Obstetrics. All communications pertaining to this Congress should be mailed direct to the American Secretary, Dr. F. Hewrotin, 353 La Salle Ave., Chicago, who will promptly furnish all information. All notifications to be forwarded should be received by August 1st. Everything points to a great success in this Congress. Though notices concerning it have been rather late in this country, already men of celebrity have promised to visit and contribute papers. Among the many foreigners who have written to the Sec. Gen. endorsing and promising support to the undertaking, may be mentioned the following eminent men: Belgium: De Roubaix, Sacre, Mirriar, Pigeolot, Charles, Sanpart, and others; Italy: Porro; La Torre, Mangiazalli, Bozzi, Morisain. Turkey: Chatazian. France: Pean, Demous, Fochier, Auvard, Doleris, Pozzi, Tarnier, Budin, Terrier, Terrillon, and others; Holland: Stokvis, Treub, Nyhoff; England: Lawson Tait, Wm. Priestly, Champneys, G. Elder, J. White, Watt Black, Thornton, Doran, Spencer, Wells, Bantock, and others; Austria: Pawlik, Albert, Chrobuk; Germany: Martin, Leopold, Sanger, Gusserow, Veit, Winckel, Hegar, Kaltenbach, Freund, Heyder and others; Finland: Engstrom, Heinricius, Pippingohold; Switzerland: Reverdin Vuillot, Russia: Slaviansky; Sweden: Saliss, Westernark; Norway. Statfeldt, Howitz, Meyer.

Any one sending the following numbers of the JOURNAL: Vol. XXIV, 1890-91, Nos. 1, 9, 12; Vol. XXVI, 1891-92, No. 1, will be paid ten cents for same.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.

# MARYLAND MEDICAL JOURNAL.

VOL. XXVI. No. 25.

BALTIMORE, APRIL 16, 1892.

NO. 577

## CONTENTS

### ORIGINAL ARTICLES.

Practical Treatment of Eczema. By Bedford Brown, M. D., of Alexandria, Va. . . . . 529

Metritis as an Initial Lesion in Pelvic Disease; Its Complications and Treatment by Electricity. By G. Betton Massey, M. D., Philadelphia. . . . . 532

A Case of Malignant Disease of the Stomach in which Gastro-Enterostomy was Considered. By John B. Roberts, M. D., Philadelphia. . . . . 536

### EDITORIAL.

The Coming Meeting of Our State Medical Society 539

A Chance for a Visit to Baltimore. . . . . 539

Tracheotomy and Intubation. . . . . 540

REVIEWS, BOOKS AND PAMPHLETS. . . . . 541

### CORRESPONDENCE.

The Cause of Phlegmasia Alba Dolens. . . . . 542

### MEDICAL PROGRESS.

"Ringworm" by Dr. Hutchins.—Origin of Papillary Cystoma of the Ovary.—Gout in the Penis and Rheumatism of the Testes.—Dr. Murphey on the Treatment of Cystitis.—The Inclined Plane in Pelvic Diseases.—National Medical Review.—The Oyster.—Treatment of Diabetes Mellitus.—Partial Starvation of the Fœtus in Cases of Contracted Pelvis.—Milk Beef-Tea.—An Unexpected Result of Building up a Venereal Pract'ce Among Men.—Something about Chloroform.—Medical Prescriptions and Drug-gists.—Treatment of Lupus by Excision. . . . . 542

MEDICAL ITEMS. . . . . 549

## Original Articles.

### PRACTICAL TREATMENT OF ECZEMA.

BY BEDFORD BROWN, M. D., OF ALEXANDRIA, VA.

A long experience teaches me that the more strictly I conform in the treatment of eczema to the principle that the disease is of a parasitic and infectious origin and nature the more successful will be the result of my therapeutic agents. Mere blandness of character of local remedies, while it may tend to lessen pruritus, exerts but little power as a curative means.

This is equally true of local remedies designed to lessen irritation and inflammation. We will find that notwithstanding the industrious use of this class of agents the disease is not lessened or cured, but that there is something back of simple irritation or inflammation, some specific influence in operation, that refuses to yield to our simple remedies. Just as in the case of syphilis, we may give all kinds of simple remedies, while the march of the disease continues on until we adopt the specific antidotes, when the infection immediately succumbs. Thus I regard eczema as a disease arising from specific parasitic infectious causes, and not a simple irritation or inflammation that can arise from any passing irritating influence.

Furthermore, I am impressed with the conviction that this specific parasitic cause must be destroyed by appropriate antidotes. There is a very large group of anti-parasitic agents in our materia medica. Among those for local purposes are sulphur and its compounds; coal and wood-tar and their numerous derivatives; mercury, iodine, boracic acid, bromine, etc.

In relation to prophylaxis, I am convinced that the leading hygienic measures are absolutely necessary to the prevention of the extension of the disease. These are isolation of the infected persons and cleanliness. I have so often seen the spread and radiation of the disease from a central point of infection that I cannot doubt its contagious character.

During the recent war inveterate eczema was exceedingly prevalent in the Confederate Army. When a case of eczema came into a tent or company of soldiers, that other cases would follow was almost a certainty. Then again, when a soldier would return home and occupy the same bed with his wife, his brother, or a friend, the companion would almost surely contract the disease.

In the past year or two the eczema has been somewhat prevalent in this community. A child belonging to a family in this town associated with another who had the disease. That child contracted eczema, went home and imparted the infection to two other children and the father. These are only a few instances given as evidence of the contagiousness of eczema.

Impressed with this idea, I believe that isolation and cleanliness are the chief prophylactics and that anti-parasitic agents are the most efficient curative remedies. In the acute stages of eczema I am in the habit of ordering the skin to be bathed at least twice a day with a lotion composed of sodii hyposulphit. ℥i, sodii borat ℥ss, aquæ ℥xij. This is a good anti-parasitic and anti-pruritic. In these early stages I begin the treatment by a moderate course of mercurials, grain j of hydrarg. chlor. mit., and an equal quantity of blue mass, until the secretions of the alimentary canal are well established. Then an alkaline course, consisting of liq. potass. citratis ℥ss, potass. bicarb. ℥ss, after each meal. These remedies in a certain proportion of cases will result in subduing the disease in the early stages, but not in all.

In inveterate eczema of the scalp a different method of treatment is necessary. After experimenting with a variety of local agents, I have found the following lotion by far the most certain:

℞.—Ol. ricini . . . . .	f℥iv.
Bay rum . . . . .	f℥ij.
Acid salicyl . . . . .	℥ij.
Resorcine . . . . .	℥i.
Quinine sulphat . . . . .	grs. x.

This very active parasiticide is to be applied over the scalp night and morning and rubbed into the skin. I believe that perseverance in the use of this remedy will not only relieve most cases of this kind but will promote the growth of the hair.

Then, again, in the advanced stages of inveterate general eczema, a modification of treatment becomes necessary. The chief internal remedial agents in this class of cases are arsenic, sulphur in some form, iron, and iodine; the sulphide of arsenic,  $\frac{1}{100}$  grain, three times a day, or the sulphide of calcium, 1 grain, three times a day. But I usually precede these medicaments with sulphur sublimat, ℥ss, potassii bitart., ℥ss, divided in chart No. x; one after meals. I feel sure that sulphur is one of the best of germicides and that the system should be saturated with the agent.

In chronic eczema, when the general health is below par, and there is a tendency to anæmia, the tinct. ferri chlor., in appropriate doses, and Fowler's solution, will be of service.

In one of the most inveterate cases of eczema that I ever saw, of the face, in an adult, a teaspoonful of the syrup of hydriodic acid, three times a day, with

local treatment, eradicated the disease. The local agents in these inveterate cases that have given me the most uniform satisfaction compose the following combination:

R <sub>x</sub> .—Lanoline . . . . .	ʒi.
Albolene . . . . .	ʒi.
Sulphur sublim. . . . .	ʒij.
Aristol . . . . .	ʒij.
Ungt. pix liq. . . . .	ʒij.

The faithful application of this ointment night and morning has served in my practice in the past few years to cure more cases of inveterate eczema than any other local remedy.

In treating parasitic disease of the skin, our germicide agents often destroy the parasite only, and do not reach the ova or germ itself. This explains why we so often relieve the local affection temporarily, apparently curing it, and after suspension of treatment the disease returns. To eradicate the disease, our agents must kill the ova as well as the parasite.

Itching is one of the most annoying features of eczema. This symptom is one of the most common results of parasitic action on the skin. The bite of the innumerable varieties of fleas, of the mosquito, of the gnat, of the flea, of the numerous species of insectile parasites that infest and attack the human skin, and the movements of minute creatures that imbed themselves in the substance of the skin, as the acarus, all produce the sensation of itching. It is not the simple penetration of the skin that causes itching as any sharp instrument that penetrates, as the needle or pin, does not produce itching, but pain. It is the irritating poisonous matter deposited by the insect that acts on the nerves of the cutis vera.

We can with equal reason assume that the deposit of the microbic organisms causing parasitic disease of the skin, as eczema and analogous affections, cause the itching peculiar to these diseases; and the best anti-parasitics will be found in the germicides to destroy the parasites. For instance, in the case of the common acarus we may use all the anti-parasitics possible without effect until the insect is destroyed by the appropriate germicides. It may be that certain parasites or microbes are only susceptible to the destructive action of certain agents. Sulphur will destroy certain species; mercury another; arsenic, iodine, resorcine, carbolic acid, salicylic acid, naphthalene, others.

The germicidal line of treatment in my experience is the only method that gives permanent success. But there is an important principle involved even in this that is necessary to success, and that is a firm and steady perseverance in the application of our therapeutic measures. The successful treatment of inveterate eczema requires all the firmness and perseverance of our character to accomplish it.

—  
OINTMENT FOR PRURITUS ANI.

R <sub>x</sub> .—Hydrargyri bichloride . . . . .	gr. jss.
Ammonii muriat . . . . .	gr. ij.
Acidi carbolici . . . . .	ʒj.
Glycerini . . . . .	ʒij.
Aquæ rosæ . . . . .	ʒvj.

M. Sig., apply locally, morning and evening.

—*St. Louis Med. and Surg. Jour.*

METRITIS AS AN INITIAL LESION IN PELVIC DISEASE; ITS  
COMPLICATIONS AND TREATMENT BY ELECTRICITY.\*

BY G. BETTON MASSEY, M. D.

The attractive field recently opened to surgical gynæcologists by the discovery that the ovaries and tubes may be amputated without invariably resulting in the death of the patient has caused an enormous preponderance of current medical literature to be directed toward diseases of these organs. So great has become the furor that little else is heard at our special societies but discussions on the wet specimens thus procured, which are brought in regularly in buckets by certain operators. This singular abundance of pathological material supplied by two organs out of an important group is calculated to make an onlooker who is, fortunately, free from what might be called the operative infection, inquire carefully into its reasons. Granting the peculiarly peccant nature of these organs as a justification, it may be asked why resort should invariably be had to amputation rather than to a more conservative operation. It may be that there is such a thing as a war-time in this work, when, as in military surgery in the field, parts of Nature's handiwork are hastily removed that a more thoughtful conservatism would have restored to health.

But it is not my purpose to discuss at present the debatable question of the proper management of inflammatory conditions of the ovaries and tubes; they are merely alluded to at this time because it is my conviction that many ovaries and tubes have recently been removed when the real seat of trouble was within the uterus.

The grounds for this conviction are derived primarily from a number of cases of post-operative pain seen in private practice and at the Dispensary for Women at Fourth and Spruce Streets. Many of these cases had enlarged and tender wombs when seen by me, and had either been made worse by the operation or left in an unchanged condition.)

In examining for tender spots by the bimanual manipulation it is exceedingly difficult to differentiate between a sensitive ovary and a tender uterus, and if one's mind is so constituted that the uterus is entirely ignored, and endometritis or metritis unthought of, a mistake is readily made. One operator declared some two years ago that he did not believe there was such a thing as endometritis. Dragging upon the tender uterus, as he did daily, in his endeavors to find salpingitis, he mistook the purport of the pain excited.

In contrast to this position it may be affirmed that inflammatory conditions of the uterus are the most frequent of all the diseases of parous women and not infrequently found in virgins. More-significant still, it may be said to be either the precedent condition or the nidus of many of the most formidable diseases in this locality, such as certain displacements, catarrhal salpingitis, pyo-salpingitis, ovaritis, cancer of the cervix, fibrosis, and many other lesser troubles. How great, then, is the necessity for its early recognition and prompt treatment!

The classical studies of this disease found in the books are most instructive, though the pathological conditions described in the several varieties of endometritis are of but little clinical use to us, since we do not often study these cases in the dead-house, and as yet but few specimens have been presented at the societies. Whether the case is one of interstitial, follicular, or polypoid endometritis it is, moreover, of secondary importance in face of the present apparently well-founded belief that they are all examples of that protean disease of mucous cavities—

\*Read before the Philadelphia County Medical Society, February 10, 1892.

microbic invasion. The several forms of cervicitis, endo-cervicitis, endometritis, and interstitial metritis are clinically distinct and largely separable, it is true, but the fact should not be lost sight of that they are all alike microbial in origin, even subinvolution being septic or trauma-septic, and hence are all mere local variations of the same disease.

The recent developments of bacteriology teach us plainly, then, that simple endometritis—a bacterial colonization of the endometrial gland—is the primal step in these progressive conditions. Whether the morbidic germ is one of the common staphylococci of pus or some other organism, it seems clear that so its conquest of the local phagocytes is due the hyperæmia, hypersecretion, and hyperplasia of the glandular substance of the endometrium, which, later, extends to other situations by either direct continuity of structure or by lymphatic absorption. The reason for the peculiar susceptibility of the uterine cavity to such invasion is easily conceived when we remember that the intra-uterine mucosa is distinctly glandular—that the endometrium is, in fact, a gland rather than a mucous membrane.

The method by which the uterine cavity becomes the culture-medium of these infections deserves some consideration. On reviewing the conditions present, particularly the ubiquity of pus-germs in the centres of population, one is disposed to ask why an infection of this region is not universal instead of the exception. The natural, healthy mucus and the temperature would seem to be an ever-present invitation. Why, then, are germs normally absent above the internal os, though so abundant below that point? The answer has never yet been given; but it can be none other than that of a body of sentinel phagocytic cells stationed in the cervical cavity to war upon morbidic germs. Remove these sentinel cells, or lower their vitality, and the resistance they present is overcome by the outer hordes.

The ineffectiveness of these vital sentinels in puerperal infection is manifest. By a flank movement or brutal charge the seeds of destruction are planted well beyond the lines. An endometritis results, which is the cause rather than the effect of the subinvolution of the muscular fibres. In the nulliparous, and particularly in virgins, the method of invasion is not so clear, though we do not have to look far to find it. The prevalence of early stages of metritis—endometritis—in pure virgins is a daily result of my inquiries. At sixteen, seventeen, and particularly between seventeen and twenty-three, in this climate, a uterine leucorrhœa is by no means uncommon in weak and delicate girls; and we do not have to adopt the harsh and generally untrue statement of Schroeder as quoted in the most recent work on this subject, Pozzi's *Gynecology*, that the germs are introduced by masturbation. The condition of the general health of these patients is the real causal factor. The germs are always in the cervix normally unless the hymen be imperforate, and they are enabled to penetrate within the uterine cavity by reason of weakness on the part of the sentinel cells.

A girl whose blood is impoverished by inherited weakness, to which is added the many imperfections in our methods of fashionable education, is in but a poor condition to marshal sentinels and defences against any morbidic attack. The logic of this view is sustained by the methods of many rational physicians in dealing with this condition in such cases. Let the blood-making organs once be restored to health, and the invaders, if not too deeply entrenched, will be driven out.

At its inception this affection is usually subacute, if we except the more virulent forms of puerperal metritis, and runs its course without material disturbances of temperature, like the analogous affections of the nasal cavity. Even

after the disease has extended so far as the Fallopian tubes, with the production of muco-purulent accumulations, the temperature may still be normal. In my experience, an acute stage is lacking, the onward march of the affection being as insidious as it is gradual. Beginning as an endometritis or endocervicitis, the patient is only conscious at first of a leucorrhœa which becomes more abundant and irritating to the vagina and vulva, and should be the sign for active and intelligent interference on the part of her physician, though of late a do-nothing policy has been advocated by some. It has been said by an eminent authority that the womb has its natural secretions, like the nose. This is, of course, true, but it should be remembered that the nasal secretion is not normally muco-purulent; as soon as pus-corpuscles habitually occur in either secretion, the existence of a diseased condition is manifestly proven.

The subsequent stages and the effects of this catarrhal endometritis are natural consequences. Accompanying the hypertrophy of the endometrium into fungoid and cryptose conditions we have a direct stimulation of the connective-tissue cells of the parenchyma. Trophic changes in this situation and general fibrosis of the body of the uterus result. Coincidentally, or at a later period, an extension upward along the mucous tract occurs, and salpingitis, ovaritis, or both, add their burdens to the suffering woman. I shall not recount the local symptoms of this conglomerate affection beyond the statement that at various periods in its course we find changes in the quantity and quality of the secretions, erosion of the os from irritating discharges, hypertrophy and tenderness of the cervix and corpus, combined with a reasonable movability of the uterus as a whole. With these facts you are all familiar. On the reflex symptoms some doubt has been thrown of late, but the best proof that pains down the limbs, in the abdomen, and in the back, with or without nervous prostration, are caused by this "irritable" uterus is given by the disappearance of such symptoms as a result of local treatment. The reason for the doubt lies in the lack of neurological training in many gynecologists, who have mistakenly treated such diseases as hysteria, neuralgia, lateral sclerosis, and locomotor ataxia as mere nervous manifestations of pelvic disease. I have elsewhere reported an instance of removal of the ovaries for pains that were due to an aggravated spastic condition; and the physicians that follow my service at the Spruce Street dispensary recently saw an even more ludicrous error of a well-known colleague: A woman applied for the relief of a pain in the side in the region of the floating ribs, making the statement that she had been under treatment for it at a neighboring dispensary for several years. The treatment had been directed entirely to the pelvic organs, and much pressure had been unsuccessfully brought to bear on her to consent to a removal of the ovaries. In spite of this treatment her pain was somewhat worse. In glancing at her back I was led to request that the corsets be removed, which revealed a most marked case of scoliosis, with corkscrew twist of the vertebræ. A properly fitting brace gave her complete relief from pain. Even a slight acquaintance with orthopædics would not hurt gynecologists; an elementary training in neurology is certainly essential to correct diagnosis in this specialty.

Besides errors of diagnosis it is possible that the present tendency to minimize the effect of uterine disease in causing backache and other neuroses is due to the failure to cure such conditions by removing scar-tissue from the cervix. Failing to cure these cases by cutting out this harmless reparative effort of nature and by removal of the appendages, the remainder of the woman is kept in bed for long periods of time under the theory that the rest-cure was the proper thing after all, and that rest was the most essential part of the rest-cure.

Clinical proof of the dissipation of these baneful symptoms by the use of means



that combat the initial microbic affection and its nutritional and hypertrophic consequences is the best proof of their correlation.

A recent case will, I think, present this proof in a strong light. A healthy young lady fell a short distance from a hammock, striking the end of the spine. She suffered immediate pain, and two weeks later applied to an intelligent gynecologist, who treated her for retroversion, and later for inflammation of the ovaries, so far as could be ascertained from the patient. After some early relief the condition became stationary. At this time the case was seen in consultation by Dr. Baer, of this city, with a view to removal of the appendages, which was, however not done for some reason. Sixteen months after the beginning of the disease the patient entered my private sanitarium in the following condition. Subjective symptoms: continuous, deep-seated scratching pain about an inch and a half above each ovary; a tender pain in the sacrum, and an inability to walk more than two squares without an intensification of these symptoms and great prostration. Objective symptoms: external evidences of perfect health, marred only by coldness of the extremities. Internal examination showed considerable leucorrhœa; uterus apparently small and in normal position, but when elevated on the finger in the posterior cul-de-sac extremely painful. Thinking the case one of posterior parametritis or ovaritis, she was treated by the vaginal galvanic method in conjunction with general electricity and massage for the incipient nervous prostration that was becoming manifest. Considerable improvement resulted, but no headway was made with this peculiar pain in the ovarian regions until it was recalled that nothing had been done directly for the endometritis. The sound, now passed for the first time, showed that the apparently small uterus had a cavity exceeding three inches. An intra-uterine positive application was therefore made, of a strength of twenty milliamperes, and this had the happy effect of checking the so-called ovarian pain permanently. Four subsequent applications of the same kind were made for the control of the discharge and the patient was restored to health and has remained well now for some time.

This patient had been kept for three months on a lounge by her previous attendant under the theory that this supposed essential of what is called the rest-cure would be of service. Shorn of its institutional control and electricity this fashionable mode of treatment is a two-edged sword that is responsible for more than one chronic invalidism. Used with such essentials, including direct electrical applications to the uterus in the class under consideration, these cases in the borderland between the domains of gynecology and neurology may be permanently restored to health, though he who essays but one part of the treatment will meet with frequent failures and disappointments.

For therapeutic purposes cases of chronic metritis are divisible into two classes that much resemble the divisions made by the late George M. Beard in cases of sexual neurasthenia in the male. In the one class the affection occurs as a purely local disease, the nervous organization of the individual being so robust that it fails to become effected by the local disturbance; in the other class a far less degree of local trouble may be found associated with profound depression and disorder of the nervous system—a disorder that seems greatly disproportioned to the local disease.

The treatment of the first class of cases is naturally entirely local, and may generally be carried out in the office, when the disease has not yet ascended to the tubes and ovaries. Various modes of treatment have been efficaciously employed, though many are now abandoned as either ineffective or dangerous. I shall limit my remarks to the local use of electricity, first prominently brought

forward by Apostoli, whose conclusions have been more than confirmed by my own experience. As in other subacute microbic affections of the glandular membranes, the galvanic current presents a typical alterative action which may be brought to bear directly upon the diseased surface, and by means of applicators that are in themselves innocuous because elastic, easily inserted, and lacking the dangerous piston action of the cotton swab. The contrast with acids or other cauterants that must be inserted by force is very great; no hooking or pulling on the cervix or other harsh methods are necessary and the local action is, moreover, strictly measurable and controllable. By reason of its greater antiseptic effect the positive pole is usually preferable, though, in the latter stages of the disease, when the endometritis has eventuated in a hyperplasia, the galvanic alternative method is better than the use of a single active pole. In subinvolution, particularly, the alternative galvanic method within the uterus is quickly curative, accompanied at each treatment by a primary faradic application.

Judging from results, the local electrical treatment seems to act in a threefold manner, each special element of the method varying in usefulness in different cases. One part of the action is a local alterative effect on the endometrium; another results in a quickened absorption of hyperplastic tissue, and still another in stimulation of the muscular fibres to immediate contraction and increased tone. The first action is most important in fungous and hæmorrhagic cases; hence, the positive pole should be used alone, with a duration of some minutes at each application. As the possibility of causing an immediate increase of muscular tone in the uterus increases, the alternative method becomes more valuable; and in recent subinvolution the faradic current alone is usually sufficient.

If, at the initial examination of a case, a reasonable doubt is present as to the preponderance at the time of the original metritic trouble or of a secondary extension into the tubes and ovaries, the intra-uterine method should be preceded by a more or less prolonged vagino-abdominal galvanic treatment; and in these cases, as well as in the second class here described in which the nervous system is affected, the value of institutional treatment is enormous. By a combination of internal and external electrical treatment, massage, diet, and partial rest, these cases can be almost invariably restored to health, unless pus-cavities have formed—an event that is much rarer than some would have us believe. It may take weeks to accomplish these results, it is true; but it is also true that it takes years for the patient to recover health after the performance of a castrating operation.

218 South Fifteenth Street.

### A CASE OF MALIGNANT DISEASE OF THE STOMACH IN WHICH GASTRO-ENTEROSTOMY WAS CONSIDERED.\*

BY JOHN B. ROBERTS, M. D.

I desire to briefly report the result of a case in which I was only deterred from making preparation for gastro-enterostomy by the debilitated condition of the patient, but in which the post-mortem findings showed the inutility of such an operation. The delay which prevented me from subjecting the patient to the expense and anxiety of so serious an abdominal operation is so justified by the pathological conditions that it has caused me to present the specimen for examination.

Upon being summoned to another State for surgical consultation, I found a man about fifty-two years of age suffering from great pain in the epigastrium.

\*Read before the Philadelphia County Medical Society, February 10, 1892.

He was vomiting large amounts of fluid. The temperature was normal, but the muscular weakness was great, and sleeplessness was pronounced. The abdomen was distended with gas, and there was a marked prominence in the neighborhood of the left hypogastrium. The patient had suffered for about four years with dyspeptic symptoms, during which time he had been under the care of many physicians. He had recently been treated by lavage, which relieved the pain temporarily, and he had suffered with such obstinate constipation as made the attending physician think that there was some obstruction in the alimentary tract. It was this as well as the excessive pain that induced him to call in surgical aid.

The character of the vomiting, the situation of the prominence in the left hypogastrium, and the general aspect of the case made it very evident to me that it was one of dilatation of the stomach. I gave an opinion that it was very possible that there was malignant disease in the neighborhood of the pylorus; but it was impossible to determine the question because of the distended abdomen, and the diagnosis was hence left undecided. The administration of food by the mouth was stopped entirely, and enemata of peptonized milk combined with whiskey were given every two hours night and day. Lavage was continued to empty the stomach and relieve pain. This line of treatment was continued for about three weeks. The patient's discomfort was relieved, the pain disappeared, the vomiting discontinued, and the consequent reduction of tympany rendered it possible to detect a hard mass below the liver in the median line. The bowels in the meantime had become regular by the occasional administration of cascara. This for two weeks, however, was not needed, because of spontaneous evacuation of the bowels, probably due to the enemata. Microscopic examination of the vomited matter showed me that blood was present in the ejecta, and I now made a diagnosis of malignant disease.

At the end of three weeks small amounts of nourishment were given by the stomach. We commenced with a drachm of peptonized milk with a few drops of whiskey every two hours, and daily diminished the amount of food administered by the rectum. Gradually the amount of food taken into the stomach was increased until it reached three ounces every two hours. The prolonged rest during the period above mentioned seemed to have been beneficial to the stomach, so that the small amounts of food given at frequent intervals were digested without pain; there was no vomiting, though the tympany became more or less prominent.

At the time he began to take food by the mouth, I told the patient that he had malignant disease of the stomach, and that exploratory examination was proper with a view of determining whether an artificial opening could be made between the stomach and intestine, or the growth removed. This was deferred until the strength of the patient should be somewhat improved under gastric alimentation. The patient, however, continued to lose ground, and died about a month after my first visit. When the food given by the stomach reached three and a half ounces he began to have pain.

The autopsy showed, as the specimen makes clear, malignant disease infiltrating about one-fourth of the long diameter of the stomach, with several nodular masses at the pylorus. The pylorus, however, is sufficiently patulous to admit readily the introduction of a finger-tip. There was, therefore, no marked obstruction. The cardia is much thinned, while the middle portion of the stomach presents the normal thickness and characteristics. An adhesion has taken place between the stomach and the liver at the point where the growth is most marked.

Gastric dilatation had occurred secondarily to malignant disease of the pylorus. The only time at which it seems to me gastro-enterostomy would have been

wise was previous to his coming under the care of Dr. H. A. Stout, who called upon me for assistance; and it is very doubtful if at any time the operation would have been beneficial. The pylorus, as shown at the autopsy, must have had an opening as large as would probably have been made had the operation in question been performed; and the infiltration of the wall of the stomach for one-third of its length would have made the area for an opening between the stomach and intestine limited. An opening would have had to be made between the thinned and dilated portion of the stomach at the cardiac extremity and the large area infiltrated with malignant growth toward the pyloric end. This, of course, could have been done, but prolongation of life would probably not have been gained.

The fact that the man was walking about and attending to business and that the tumor presented no external manifestation make it extremely probable that an operation would not have been suggested previously to the time he came under the care of the physician who consulted me, except by an enthusiast.

I present the case partly because of the interesting character of the specimen and partly as a contribution to a branch of abdominal surgery which is assuming increased importance.

The recent series of cases reported by Dr. N. Senn have been read by me with great interest; but the conclusion has almost been forced upon me that many of them were cases that scarcely justified operative procedure. Perhaps I am too conservative; but may it not be that he is too enthusiastic?

#### PELVIMETRY.

The practitioner is liable to be consulted by non-pregnant women afflicted with spinal disease who desire to marry, yet are afraid that some deformity of the pelvis may exist.

Writing upon this subject in the *Med. News*, Dr. J. Whitridge Williams says: In non-pregnant women with lax abdominal walls we may employ the so-called external direct method to which Credé and Hardie called attention some years ago, and which Dr. H. A. Kelly is now engaged in studying and testing.

In this method the woman is placed on her back and the abdominal walls gently pressed in by the tips of the fingers of the left hand, till the tip of the middle finger rests over the promontory; then the palmar surface of the hand is brought down upon the symphysis, and with the finger-nail of the right index-finger we mark the point at which the palmar surface crosses the upper surface of the symphysis. This distance, without making any deduction for the thickness of the abdominal walls, represents the conjugata vera with tolerable exactness—within from  $\frac{1}{2}$  to 1 cm.—and affords a ready, accurate, and convenient method of measurement for gynecological cases and in the early months of pregnancy.

Dr. A. C. Simonton, in the *Journal of the American Medical Association*, writes of the position of the human nose in relation to the eyes, and comments on the fact that no text-book on or teacher of ophthalmology calls attention to it. He has found by measuring a number of faces that the eyes are not equi-distant from the nose, but that one pupil is usually from one-sixteenth to one-eighth of an inch further away. As glasses are ground and frames fitted without considering this lack of symmetry, he believes that a decentering of lenses results, which, in some cases, causes the patients to refuse them, though they correct the error of refraction perfectly. He advocates a new form of prescription, in which the distance of each pupil from the nose, as well as the distance between the pupils, shall be given, and the grinding centered to the eye and not to the frame.

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BALTIMORE, APRIL 16, 1892.

**Editorial.****THE COMING MEETING OF OUR STATE MEDICAL SOCIETY.**

We learn that the annual session of the Medical and Chirurgical Faculty of Maryland will be held in the Hall of the Faculty during the four days beginning Tuesday, April 26th.

The annual oration is to be delivered by Dr. F. Lange, of New York, on a difficult subject of clinical interest to every practitioner. We understand that many of the best workers in the profession of our State have promised papers. A banquet following immediately after the annual address will afford excellent opportunity for the cultivation of new acquaintanceships and the renewal of old associations.

As far as we can see, there is absolutely no excuse for the indifference which many practitioners show with regard to the welfare of this, our only representative State society.

Additional interest will attach to this session of the Faculty as the first opportunity for the selection of members of the Board of State Medical Examiners under the new law just signed by our Governor.

Programmes containing further information will shortly be issued by the Secretary of the Faculty, Dr. G. Lane Taneyhill, 1103 Madison Avenue, Baltimore. The titles of all reports and papers must be sent to Dr. Taneyhill at least one week before the beginning of the session.

**A CHANCE FOR A VISIT TO BALTIMORE.**

We suggest to the members of the medical societies of neighboring States that they come as delegates from their societies to our State Medical Faculty, April 26th to 30th.

As the annual address and the banquet will be given the same evening, unusual attractions are offered to physicians who can spare but one day from their practice.

Baltimore is not, like Chicago, revelling in an epidemic of bad water and typhoid fever.

Thanks to abundance of water and occasional showers, the city is healthful, even though its streets are unswept and unsprinkled by its sanitary force.

Again, Baltimore is possessed by a continual "boom." It is greatly improving in appearance. It grows apace, affords a better field for investments than phenomenal mushroom towns of other parts of the country. It possesses a great university for men, a first-rate college for women; some of the finest libraries in the country; and a wealthy hospital with post-graduate courses unsurpassed for exactness and equipment in the world.

A hearty welcome is offered by the Faculty to all medical visitors.

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### TRACHEOTOMY AND INTUBATION.

There is a very instructive article on this subject in the *Medical News*, of April 9, 1892, by Dr. Richard B. Faulkner, of Allegheny, Pa. The author has collected from many practitioners of large experience and wide reputation their views in regard to certain questions arising in relation to the comparative merits of tracheotomy and intubation in cases where there is occluding membrane in the larynx.

We must, of course, expect that opinions on such a subject will be more or less warped by the "personal equation" of the operator, who may be much more familiar with, and expert in, the one operation than in the other. It is clear, however, that intubation gets the worst of it in the discussion. The inferences that we deduct from the article are that intubation should be done by a skilled laryngoscopist of *years'* experience with manipulations of the larynx; and that the instruments for instant tracheotomy should be at hand, because the introduction may cause immediate suffocation.

Among the objections to the use of the tube are that it may force membrane down into the trachea and occlude it; that it sometimes perforates, and generally irritates, the larynx and trachea; that its introduction and extraction require great skill; that the tube may slip down into the bronchi; that free coughing out of mucus and detritus is not secured as in tracheotomy; and that the intubation tube is liable to be obstructed at any moment, leading to instant death, unless an attendant skillful enough to remove it be near at hand.

It is asserted, likewise, that the mortality after intubation is increasing, so that it approaches that of tracheotomy; and the suggestion is made that where no laryngoscope was used, many cases of spasm of the vocal cords may have been reported as membranous laryngitis requiring intubation.

In the closing paragraph, A. Jacobi is quoted as having declared, at the Berlin Congress, in 1890, that in membranous laryngitis he puts his faith in mercurials, finding that, if he rapidly induces the constitutional effects of mercury, cases of fibrinous tracheo-bronchitis get well in an unexpected manner; that cases of gen-

eral and laryngeal diphtheria may similarly recover; and that the beneficial effects of mercury are not limited to cases of stenosis, but apply also to those of sepsis.

Dr. Jacobi is said to have abandoned tracheotomy. One would suppose that the best results would be obtained by retaining tracheotomy and at the same time getting all the help possible from the free and careful use of mercurials.

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### Reviews, Books and Pamphlets.

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*Transactions of the Medical and Chirurgical Faculty of Maryland.* Semi-annual session, held at Cambridge, Md., November, 1890, and ninety-third annual session, held at Baltimore, April, 1891. Baltimore: Griffin, Curley & Co.

This issue of the Transactions of our State Medical Society, although delayed nearly a year in making its public debut—the delay being ascribed to economy—presents to the reader not only a handsome appearance but a very creditable array of papers and addresses, with themes ranging from extreme scientific problems, to difficulties met with in daily practice, and hygienic and legislative advances demanded by modern progress.

There seems to be needed by the State society a financial Moses to lead it out of the bondage of poverty and unsuccessful business methods into an estate of prosperity in money matters commensurate with its evident success in literary and medical departments.

The poverty of the Faculty is simply a disgrace to the profession of Maryland, which has wealth enough to enable its representative society to take a decent stand among sister State societies.

*A Practical Manual of Diseases of the Skin.* By GEORGE H. ROHE, M. D., Professor of Materia Medica, Therapeutics and Hygiene, and formerly Professor of Dermatology in the College of Physicians and Surgeons, Baltimore, etc. Assisted by J. WILLIAM LORD, A. B., M. D., Lecturer on Dermatology and Bandaging in the College of Physicians and Surgeons; Assistant Physician to the Skin Department in the Dispensary of Johns Hopkins Hospital. No. 13 in the Physicians' and Students' Ready-Reference Series, In one neat 12mo volume, 303 pages. Extra cloth, price \$1.25, net. Philadelphia. The F. A. Davis Co., publishers, 1231 Filbert St.

The physician or student wishing a hand-book of skin diseases at a moderate price cannot do better than secure this little work. It is neatly printed, compact, and well arranged and indexed. The matter is not original, nor are illustrations inserted. There is, however, a good series of useful prescriptions at the end of the volume. We recommend it, not simply out of interest in the work of our friend and fellow citizen, Dr. Rohe, but because it suits the needs of the general practitioner who wants to know what to do for his patient and don't care about disputed theories.

*The Modern Treatment of Hip-Disease.* (Physicians' Leisure Library Series.) A Practical Resumé of Modern Methods Employed in the Treatment of Chronic Articular Ostitis of the Hip. By CHARLES F. STILLMAN, M. Sc., M. D., Chicago, Late Professor of Orthopedic Surgery in the Chicago Polyclinic. 1891. George S. Davis, Detroit, Mich. Price 25 cents.

This little book of 118 pages aims to present to practitioners and medical

students the most recent views held by orthopedic writers upon the subject. Both publications and private letters have been utilized. 60 neat illustrations add brightness to its pages.

### Correspondence.

#### THE CAUSE OF PHLEGMASIA ALBA DOLENS.

*Editor Maryland Medical Journal:*

I was very much interested in Dr. Brinton's paper on phlegmasia alba dolens, read at the last meeting of the Clinical Society of Maryland, as I have had some experience with that disease. I notice, in discussing the subject no one spoke of post-partum hæmorrhage or the assumption of the erect position as having anything to do with causing the disease. I think if we would inquire into the matter we would find that nearly all of these cases had occurred after post-partum hæmorrhage and after the puerperal woman had been sitting up or standing. As hæmorrhage most always necessitates the introduction of the hand into the uterus it might give weight to the argument in favor of the septic origin of the disease. I believe the disease is mainly due to abandoning the horizontal posture whilst in an enfeebled condition.

Yours truly, EDWARD ANDERSON, M. D.

### Medical Progress.

#### "RINGWORM" BY DR. HUTCHINS.

The treatment of the various forms of ringworm is briefly given by this writer in the *Atlanta Med. and Surg. Jour.*, March, 1892, as follows:

The first case which I treated in Atlanta was a case of ringworm of the scrotal-femoral region. For the preceding two years I had had more to do with carrying out other people's prescriptions than with writing them. So I forgot whether it was *chrysarobin* or *pyrogallic acid*, the latter of which I have never seen prescribed for it, that was "good" in ringworm. I ordered the wrong one in theory, but that one prescription convinced me there was nothing better for cutaneous ringworm. I wrote the following:

R.—Acid pyrogallic . . . . . gr. xv.  
Collodii . . . . . ʒi.

M. Sig.—Paint on often enough to keep lesions covered.

The few cases of ordinary ringworm of the skin and the larger number of scrotal-femoral ringworm have all yielded quite promptly to this treatment. It may require to be weakened or increased in strength, according to the quality of skin upon which it is used. Whether the irritative action of pyrogallic acid does the work or the occlusion of air by the collodion, or whether the former destroys the fungus, I do not know.

For ringworm of the scalp I have used bichloride of mercury, one to two grains, kerosene oil one ounce. This combination was mentioned to me by Dr. Elliot, of New York, last spring, and he reported excellent results from its use in institution practice. In October, 1891, Dr. C. G. Kerly reported (*New York Med. Jour.*), 31 cases successfully treated with the following: Kerosene and olive oil, aa. 15; bichloride, one-eighth of 1 part; alcohol sufficient to solution. Irritation produced was treated with simple salves. (The gentleman reporting this article



for Unna's long-named, German Skin *Journal*, says it was not mentioned whether these were old or new cases, and that it was well known that irritants can cure a recent case). The bichloride in kerosene alone is doubtfully soluble, but the effect has been perfectly satisfactory. The irritation produced was only slight and accompanied by the formation of thin plates of scale covering the parts treated, but in one case, predisposed to eczema, there was a diffuse eczematous outbreak upon the scalp. In none of the cases was the commonly recommended epilation practiced.

Various treatment was used on the single case of ringworm of the beard, but the results were not such as to justify detailing the treatment here.

#### THE ORIGIN OF PAPILLARY CYSTOMA OF THE OVARY.

In an elaborate article upon this subject in the *Johns Hopkins Hospital Bulletin*, Nov. 18, Dr. J. Whitridge Williams draws the following conclusions:

In conclusion, I will sum up the results of my work, and in so doing will not commit myself to any single theory of development to the exclusion of all others; for I believe that they may be developed from one of several sources; and it is not impossible that different portions of the same growth may have developed from different structures, though I am unable to state positively that this is ever the case.

As the result of my observations, I would almost entirely reject the Wolffian body theory and consider the growths to be purely ovarian. The papillary ovarian cystomata may be derived from the following sources:

1. The Graafian follicle. This is probably the usual point of origin for the development of these growths; and according as the membrana granulosa is ciliated or not, so the growth will be of the ciliated or non-ciliated variety; and according as the affected follicles grow within the folds of the broad ligament or not so the growth will be intra-ligamentous or not.

2. The germinal epithelium. This is the most frequent and perhaps the only source of origin for the superficial papilloma, and probably is frequently the starting point for the usual form of the multilocular papillary cystoma.

3. The tubal epithelium. From a consideration of the conditions in Case 1, it is probable that some cases are developed from ingrowths of the epithelium of the tube into the stroma of the ovary. This mode of origin is, however, not yet absolutely proven.

These conclusions tend to prove that the work of all the later investigators in this direction, except those who accepted the Wolffian body theory of development, has been accurate and of real scientific value; but no one observer seems to have met with all of the different forms of development presented in this article.

#### GOUT IN THE PENIS AND RHEUMATISM OF THE TESTES.

A correspondent of the *Brit. Med. Jour.*, January 30, 1892, relates these instances:

The patient was a captain in the Royal Navy, married, and near 60 years of age, and—singular to mention—I was called upon the following summer to attend him for a second attack, the penis then being the principal part that was mostly affected. It was greatly swollen, with priapism, there being so small an orifice for the escape of urine (phimosis) that I had to slit up the prepuce. The organ was enveloped in lint, kept constantly wet with a sedative lotion; it was very tense, and frightfully painful. The testes were unaffected. There was much ardor urinæ; at that time he did not complain of any particular uneasiness about any of the joints. Potas. bicarb. ꝑ. colchico et magnes. sulph. were given

in frequent doses, so that the bowels were freely relieved. The diet consisted chiefly of milk gruel. The attack of urethritis was followed by a copious discharge of muco-purulent matter. Upon the fifth day of the attack the priapism yielded, after which pains of a slight and transient character were manifested. The patient had occasional attacks of gout in right foot.

At the time I considered the cases somewhat unique, not having met with a similar one during twenty years' work. Rheumatism I have often witnessed attacking the testes, ending in urethritis. I regarded the case as one of gout attacking the penis, owing to the highly acid condition of the urine. No doubt having to relieve the phimosis at an early stage of the disease by operation contributed to a very great degree to the brevity of the attack, with the alkaline treatment then carried out.

#### DR. MURPHEY ON THE TREATMENT OF CYSTITIS.

In an article upon cystitis in the *Atlanta Med. and. Surg. Jour.*, March, 1892, Dr. Murphey, of Atlanta, writes:

In the treatment of cystitis, the measure of the first and greatest importance is absolute rest. The rest should be in bed, with hips slightly raised, in order that pressure may be taken off the neck of the bladder. Constitutional treatment consists in regulating the character of the urine, so that it shall be unirritating to the diseased bladder.

To render the urine less irritating give alkaline diuretics, demulcent drinks, etc. Citrate of potash is one of the most valuable alkaline diuretics and is often advantageously combined with buchu, uva ursi, triticum repens.

Opium should be used to allay pain, lessen excitability and relieve spasmodic action. I usually prefer suppositories of opium and belladonna, but if the spasm alone is causing the pain belladonna alone will often relieve it, which is preferable. Poultices over the hypogastrium and perineum or hip-baths are useful. The bowels should be kept regular and free in order to secure free action of the portal circulation and prevent straining at stool. Free action of the skin and bowels relieves the taxed kidneys and bladder, giving them less to do. Saline purgatives are better suited for this purpose. Sulphate of magnesia or a glass of a laxative mineral water given before breakfast usually acts nicely. Digestion should be watched with care; in fact, I have found cases that could not be relieved until the state of the digestion was improved.

The diet is an important factor that should not be overlooked; irritating articles of food should not be allowed; spirits, alcohol in all forms must not be allowed; coffee and tea should not be allowed. Nothing should be taken that disagrees in the least with digestion.

In a mild case of cystitis, I do not adhere strictly to all of the rules laid down here, but let the patient continue at business if desired, and by proper care and treatment he may be relieved in a short time. For example, the urine is too acid or too alkaline; acts sometimes like a foreign body; it irritates, and the bladder will make efforts to expel it. Deposits of any urinary solids in the viscus are likely to produce an irritable condition. Such cases being of a mild form can readily be relieved if not allowed to stand too long.

In advanced stages of cystitis local treatment can be employed advantageously, by washing out the bladder carefully with medicated injections.

#### THE INCLINED PLANE IN PELVIC DISEASES.

At a recent meeting of the Alumni Association of the Woman's Hospital, New York, Dr. T. A. Emmet, read an interesting paper (*Amer. Jour. Obst.*, March, 1892), on this subject,

Dr. Emmet said we had in the treatment of diseases of women a most valuable adjunct in the continued use of the inclined plane. While he recognized the tendency in human nature to exaggerate the value of any given procedure, he yet did not hesitate to give it as his observation that there seemed to be scarcely any condition of disease in the female pelvis which was not benefited to some extent by maintaining the recumbent position, with the foot of the bed elevated from twelve to eighteen inches. If it were not elevated as much as twelve inches the benefit would not be derived, because the intended effect of gravity on the pelvic organs and circulation would not be obtained. Having recognized the efficiency of this posture treatment for ten years, and noticed that patients were thus often enabled to get sleep who without it lay awake all night, he was at first disposed to attribute it to increased blood supply in the brain, but later he became convinced that it was due to lessened circulation in the pelvis. He had never tried it on patients who were fleshy or suffering from cardiac trouble. Several patients had continued its use from choice after the indications for it had ceased, because they were better able to sleep in the inclined than in the horizontal plane.

The position was of marked value in the treatment of enlarged and prolapsed ovaries, in threatened attacks of pelvic peritonitis, and in cases of pelvic inflammation where tamponing of the vagina had so often proven of benefit. Indeed, he had cured several cases of tubal disease in this way. The relief had been most prompt in irritation of the bladder, which so often attended local peritonitis about the utero-sacral ligaments. It was a matter of experimentation to find what degree of elevation was necessary in a given case to afford relief. One woman with a fibroid tumor bled much less after assuming this posture, and what was apparently rapidly becoming a large growth was checked in its progress. The treatment could be carried on for weeks without any loss of strength, but, on the contrary, with gain, if attention were given the general condition. Unless there were some contra-indication, massage would often prove a useful adjunct.

A most interesting case treated in this way was that of a woman who had suffered repeatedly from attacks of peritonitis, rigors, elevation of the temperature, slight discharge of pus from the vagina. When Dr. Emmet examined her there was a pus tube about the size of his wrist; the uterus was fixed and crowded against the bladder; her general and local condition was so unpromising that he had not the courage to operate for removal of the tubes until he should have tried to improve her health.

Having already had several cases recover without an operation he tried the inclined plane, elevating the foot of the bed 18 inches. By this means the tube began to drain itself through the uterus and in less than a week the temperature became normal. She now went out for office treatment and the pus ceased to flow; pain, chills and fever returning. She was put back on the inclined bed and kept there five weeks, at the end of which time the pus had all drained away and she had menstruated once; the tube being only about the size of the little finger and the uterus movable. She was still improving but not yet well.

The other specialists who discussed Dr. Emmet's paper agreed that the method was well worth a careful trial.

#### THE NATIONAL MEDICAL REVIEW.

We welcome to the field of journalism the new Washington monthly, the *National Medical Review*. The two numbers received present an excellent review of medical matter of general and clinical interest, chiefly if not wholly from the pen of the gifted editor, Dr. Chas. H. Stowell. The journal enters a somewhat

untried field, containing so far no original articles, but offering in a pleasant and readable style brief notes on numerous topics of interest and profit to the practitioner.

May success attend its course!

#### THE OYSTER.

Discussing the increase of oyster-planting in France, where very successful efforts to grow the bivalve for market have been recently made, Consul Knowles (*Reports of Consuls of the U. S.*, October, 1891), gives a bit of history which seems to show that our Maryland people are a good deal further behind the times than we thought they were. He says: The history of the oyster has been too often told to suffer repetition here. Certain it is that the favored dainty was highly popular with the ancients, for Pliny, to whom one may always go for information, states that their cultivation was practiced extensively along the Tyrrhenian coast, and that one Sergius Orata, who had an oyster bed at Baiæ, "not for gluttony, but for the sake of gain," derived a large income from the same. Alexander, in his conquest of India (B. C. 324), declares that he found oysters a foot long. Modern fishermen may accept or distrust this assertion, as they like; for, whereas the illustrious Grecian general was noted for his integrity, there is no subject which favors in such a pronounced degree the fanciful flights of the imagination as that which is represented by the twelfth sign of the zodiac.

#### TREATMENT OF DIABETES MELLITUS.

In a clinical lecture published in the *Med. and Surg. Rep.*, December 26, 1891, Dr. Francis Delafield, of New York, says: If you tell a patient he must not eat such and such articles of food, and he then goes away from your office and eats very little of anything; such a man as that will not do well at all. You must find out what articles of diet they like to eat and what things they do not like to eat. Bear in mind that the diabetic, as well as other patients, are people whom it is very necessary to feed properly and they have an appetite only for the articles of diet that they like best. This is a matter of a great deal of importance in the management of your patients and is a subject you should study in detail. There are people whom you can feed very well if you give them the right things to eat; and who would sooner starve than eat what they do not like.

Now, as regards the use of medicine. There are a number of different medicines that we give for diabetes, and we give them all in a very empirical and uncertain sort of way. We do not know why any one of them does good, and we are not sure that any of them will do good in a given case, but we know, on the other hand, that each of them is capable of doing some good in certain cases. The solution of the bromide of arsenic is a preparation that has been given a good deal, and with some success, in a considerable number of cases. In other cases, it does no good whatever. The same is true of the other preparations of arsenic, and according to the experience of different physicians, there are some who think that arsenic is of service in diabetes, while there are others who think it is of no use whatever. Then, beside arsenic and its preparations, opium is given either in the form of opium or of morphine or codeine. Codeine is the favorite preparation for this purpose, and, in my opinion, is the best form in which to give it. The trouble with all the forms of this drug is that it is very easy to begin its use but a very difficult thing to stop it after it has been taken for a considerable length of time. Then sulphide of calcium, given in doses of a quarter of a grain and run up to a half or one grain three or four times a day, is also used. This drug again answers for some patients and not for others.

Iodoform has also been given for this condition, and there are some who report good results from its use. In fact, I have seen some patients myself benefited by the use of this drug. It is generally given in pills or capsules in the proportion of one to three grains three or four times a day. Antipyrin, which has been given for almost everything, has also been given for diabetes, and good results have been reported from its use. I could go over a large number of drugs that have been given with more or less good results for the cure of diabetes.

The best thing that I can do for the patient before us is to advise him about the proper place for him to live in and the food suitable for his condition. As regards his medicinal treatment, instead of continuing with the use of the bromide of arsenic I will give him arsenious acid, in combination with ipecac and rhubarb. A good formula is

B.—Acidi arseniosi	gr. 1-30
Pulv ipecac.	gr. 1-50
Pulv rhei	gr. 1-50

M. Sig.—One pill three times a day.

#### PARTIAL STARVATION OF THE FŒTUS IN CASES OF CONTRACTED PELVIS.

In discussing premature labor (*Amer. Jour. Obst.*, March, 1892), Dr. Bettman says:

This paper would not be complete without reference to an entirely new solution to the question of moderately contracted pelvis proposed by L. Prochownick, of Hamburg, in August, 1889. Prochownick tried the novel experiment of stunting the growth of the fœtus in utero by starving the mother, or, rather, by placing the mother on the ordinary diet for diabetics. His first patient had been delivered of four children; two prematurely, one by version, one by perforation; and all the infants had perished. Towards the close of the fifth pregnancy the patient was placed on the strict diet, and was delivered at term of a healthy infant weighing five pounds, three ounces, with adipose layer practically wanting, and with very movable skull bones. The infant developed rapidly and normally. Encouraged by his success, he repeated the experiment in two similar cases, and both the infants born were thin, had movable skull bones, and thrived perfectly. Thus three mothers who had born eight dead children were enabled by these means to rear living offspring. Prochownick has found imitators, and in March, 1890, A. v. Brehm reported a fourth successful case in the *St. Petersburg Medicinische Wochenschrift*.

The departure of Prochownick is so novel, is based on such rational physiology and has been so signally successful that it merits not only the general attention of the obstetric world, but also general imitation in appropriate cases.

#### MILK BEEF-TEA.

Dr. Alfred T. Schofield writes: Recently I tried an experiment, so entirely satisfactory and yet so ridiculously simple, that my only excuse for recording it in the pages of the *Brit. Med. Jour.* is that it appears to be almost quite unknown to either hospital authorities or private nurses. I have for many years been engaged in studying invalid foods and varieties of beef-tea and beef-essences, and yet, I am ashamed to say, that never till last week did the simple fact dawn on me that beef-tea could be made as well with milk as with water, the result being to form a new invalid food of the most nourishing character.

The article may be, and doubtless is, familiar to many of your readers, for surely the experiment must have been frequently tried, and still the fact remains that I have not yet found a hospital official, a sick nurse, or a private person who knows anything about it. One thing is therefore certain, that at any rate it is not

nearly so well known as it should be. Take half a pound of gravy beef chopped up small, and let it soak in a little salt and water for a few minutes, and then proceed to make the beef-tea with milk instead of water, using the proportion of a pound to a pint, straining off the meat when done and serving hot. The result is delicious.

It can, of course, be made with veal or chicken to even greater perfection. In fact, once the idea is grasped, the varieties are endless, and yet I have seen no invalid cooking books, (though many of them give a dozen or more varieties of beef-teas and of milk compounds), that make any reference to "milk beef-tea."

#### AN UNEXPECTED RESULT OF BUILDING UP A VENERAL PRACTICE AMONG MEN.

In discussing Dr. Bedford Brown's paper at the December meeting of the Southern Surgical and Gynæcological Association, Dr. Price (*Atlanta Med. and Surg. Jour.*, March, 1892), said:

While a resident physician in the Old Philadelphia Dispensary, it was then the rule not to treat venereal diseases in the institution, but I asked as a special favor of the Secretary that I be permitted to treat all venereal diseases after hours, as I was anxious to have a little experience just then in that direction. Consent was given, and I soon built up a huge clinic for the treatment of venereal diseases. I call attention to this to verify my position in gynæcology. I soon had a clinic that took me an hour and a half or two hours to manage. I had a large number of cases of gonorrhœa, chancroid, bubo, phimosi, prostatic trouble, vesical and renal troubles. I took my meals, my dinner and sometimes my breakfast with my brother. I had a room in the dispensary. My rule was to go to a restaurant near by to get my lunch, and sometimes my breakfast if I had slept late. I soon discovered that it was impossible to dine at a single restaurant without being waited on by some one whom I was treating for bubo or gonorrhœa. I had to give up going to restaurants to take my meals. Some of these patients would salute me: "Hello, Doc, what will you have?" I had to go back to my brother's and take my meals with him. I call your attention to this matter to emphasize the fact that I have since operated upon the wives of those men for huge pus-tubes, ovarian abscesses, not by the dozen, but by the hundreds. I am speaking to prominent practitioners, men of large experience and good judgment. I am speaking from the standpoint of a specialist. For the last six years I have treated more cases of pelvic diseases than any one else in Philadelphia.

#### SOMETHING ABOUT CHLOROFORM.

A correspondent of the *Therapeutic Gazette*, Feb., 1892, writes: An interesting meeting of the Physiological Society was held in London recently. One of the most important papers was a description by Dr. du Bois-Reymond of the physiological effects of the new "Pictet's" chloroform and of the impurities separated out during its manufacture. It will be remembered that Pictet has recently shown that even the purest commercial chloroform is not "absolute," but can, by the action of intense cold, be separated into two portions—a crystalline (absolute chloroform), and a liquid, which contains the impurities. Both these portions have been tested physiologically by Dr. du Bois-Reymond, who finds that the pure chloroform, as compared with the purest commercial drug, is toxic only in the proportion of 7 to 10. The impure residues are, however, highly poisonous, and it is likely that many of the untoward effects of chloroform administration may be due to these bodies. In view of the large number of recent deaths under chloroform, these researches of Pictet and of du Bois-Reymond

become of the highest interest. It is to be hoped that the profession will soon have an opportunity of testing the new chloroform for themselves. A detailed account of the results which have been obtained with it will shortly appear both in German and English.

#### MEDICAL PRESCRIPTIONS AND DRUGGISTS.

This perennial subject has lately been discussed in letters to the *Pharmaceutical Journal*. The medical writers complain that old prescriptions are redispensed by chemists over and over again, often when the condition and case of the patient make it very unsuitable and even dangerous. The chemists recommend as a remedy for this that the medical practitioner who wishes to cease dispensing should retain a particular chemist, and have an understanding with him not to dispense particular prescriptions more than once and without special authorization. This is an arrangement that may be worked honorably on both sides. But it is not so satisfactory as one in which the practitioner is independent of all chemists and the patient pays for the prescription. After all, if the patient uses a prescription on another occasion than that on which it was prescribed, he does so at his own risk. . . . There is one evil which they entirely ignore, and which is of far graver import than those complained of, viz., the assumption of an air of medical knowledge and learning by druggists in cases that would puzzle medical men themselves, and the use to which they put their familiarity with prescriptions, viz., repeating them for others and prescribing them. Some druggists—we should be sorry to think more than a few—by a system of inquiry learn the general nature of the cases for which prescriptions are written, and then apply them to what they regard as similar cases. If general practitioners and chemists are to come to better relations, there must be a more perfect and delicate understanding on such practices.—*Lancet*, April 2.

#### TREATMENT OF LUPUS BY EXCISION.

Kramer (*Centralbl. f. Chir.*, No. 8, 1892), holds that the present methods of treating lupus by caustics and by scraping are very unsatisfactory, and advocates excision of the whole of the diseased portion of skin. This is removed with the knife together with the subcutaneous tissue as far down as the muscular layer. After an interval of about 12 days, when granulations have formed, the defect is closed either by transplantation after Thiersch's method, or by a plastic operation. The author states that he has carried out this treatment in eleven cases during the past two years, and that it has invariably resulted in permanent healing at the seat of operation. Although this method is more applicable to cases in which a portion of an extremity or of the trunk is affected, it may be practised with good results in many cases of lupus of the face. In this region excision should be performed as early as possible; and even if the wound be an extensive one the surgeon will be able to close it, thanks to the improved methods of transplantation, implantation, and plastic procedure. The scar thus formed, though more apparent than that produced after other methods of treatment, has the advantage of being quite sound, and free from any remains of the disease.—*Brit. Med. Jour.*, April 2.

#### Medical Items.

Professor Credé, the distinguished gynecologist of Leipsic, is dead.

A German edition of the second revision of Gower's book on the Nervous System has just been published by Cohen and Bonn, and we understand that an Italian translation is nearly ready.

In the *Boston Medical and Surgical Journal*, March 17, 1892, Dr. C. P. Strong presents a study in "the relief of salpingitis by dilatation and drainage of the uterus." His method seems heroic, but he says it is safe. At any rate it is a move in the right direction.

The Mississippi Valley Medical Association will hold its Eighteenth Annual Session at Cincinnati, Wednesday, Thursday and Friday, October 12th, 13th and 14th, 1892. A large attendance and a valuable programme are expected. Chas. A. L. Reed, President, Cincinnati; E. S. McKee, M. D., Secretary, Cincinnati.

At a coroner's inquest the other day, a novel cause of death was brought to light. A little girl, eleven years old, was playing in the street with a penny toy balloon, and during a sudden inspiration, this was drawn into the upper air-passages. Death from asphyxia resulted before medical aid could be summoned, and at the autopsy the balloon was found lodged in the throat.—*Boston Med. and Surg. Jour.*

The Faculty of the College of Physicians and Surgeons on April 12th announced the appointment of Dr. Standish McCleary as resident physician at the City Hospital; Dr. H. H. Hayden, first assistant; Dr. J. Newton Lewis, second assistant, and Dr. M. Rosenthal, third assistant. Dr. W. W. Frames was appointed resident physician at the Maternite Hospital, on Lombard Street, and Dr. J. H. Fore was appointed resident physician at Bayview. Dr. R. C. Eve was appointed assistant at Bayview.

Dr. James Startin writes (*Brit. Med. Jour.*): My attention has lately been drawn to some obstinate cases of local eczema occurring on the foreheads of men, especially young men; and on looking for a probable cause, I found that the ordinary leather lining of hats—that is, the part that comes next to the skin on the forehead, more particularly in the high hat—is whitened and glazed with arsenic and other irritating substances. Many times I have been puzzled to know why the ordinary remedies prescribed for this peculiar cutaneous eruption, simulating eczema in every respect, would not benefit the disease.

The commencement of the Maryland College of Pharmacy was held in Harris's Academy of Music Tuesday night. The exercises began with prayer by the Rev. Dr. Julins E. Grammer. The names of the graduates were announced by Prof. Charles Caspari. The degrees were conferred by the President, Prof. Louis Dohme, and the prizes were conferred by Prof. William Simon. Rev. Wayland D. Ball made the address to the graduates, and Henry R. Cheers delivered the valedictory. The first college prize, the Simon analytical prize and the practical pharmacy prize were awarded to Harry L. Leeke; the second college prize to Edward Hoffmeister; the third college prize to Walter L. Richardson and the alumni prize to Henry R. Cheers. The prizes were gold medals. Those entitled to honorable mention were Gustav C. Thiene, Harvey G. Beck, E. D. Fisher, John E. Seebold, Harry L. Leeke and Edward Quandt. The junior students entitled to honorable mention were Thomas Reed, Walter Moore, George H. Schwinn and E. T. Hargrove.

Any one sending the following numbers of the JOURNAL: Vol. XXIV, 1890-91, Nos. 1, 9, 12; will be paid ten cents for same.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 209 Park Ave., in person or by letter.



# MARYLAND MEDICAL JOURNAL.

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## CONTENTS

### ORIGINAL ARTICLES.

- An Explanation of the Cause of the Prevalence of Echinococcus Hominis in Iceland. By Wm. Lee Howard, Ph. D., M. D., Baltimore. . . . . 551
- Free Dispensaries: Their Relation to the Profession, and to the Public. By S. A. Keene, M. D., Baltimore. . . . . 553

### SOCIETY REPORTS.

- Baltimore Medical Association. February 8th Meeting. Acute Catarrh of Nose and Posterior Nares. Influenza. . . . . 556
- Gynæcological and Obstetrical Society of Baltimore. March Meeting. Doederlein's Work on Vaginal Secretion. . . . . 558

### EDITORIAL.

- A Private Suggestion to Subscribers. . . . . 560
- Some More Facts About the "Bacillus Diptheriæ." . . . . 560

### REVIEWS, BOOKS AND PAMPHLETS. . . . . 562

### MEDICAL PROGRESS.

- The Coming Faculty Meeting.—Resuscitation by Peritoneal Transfusion.—Nerve-Stretching in Neuralgia.—The Nature of Angina Pectoris.—A Cataractous Family.—Perforation of Typhoid Ulcer.—Painful Toe.—The Epilepsy of Cerebral Palsy in Children.—Gouty Eyelids.—Abolition of Electrical Execution. . . . . 563

### MEDICAL ITEMS. . . . . 572

## Original Articles.

### AN EXPLANATION OF THE CAUSE OF THE PREVALENCE OF ECHINOCOCCUS HOMINIS IN ICELAND.

BY WILLIAM LEE HOWARD, PH. D., M. D., OF BALTIMORE.

In reading Roberts' Practice of Medicine the other day I ran across the following statements: "A hydatid tumor is derived from the development of embryos of the *tania echinococcus*, each of which produces a scolex, named *echinococcus hominis*, and these scolices become enclosed in cysts. This variety of tape-worm infects dogs and wolves, and it is supposed that fragments are evacuated in their excreta, the ova of which are subsequently set free, become mixed with water and food, and are thus introduced into the alimentary canal of a human being. When the embryos are liberated, they bore the walls of the stomach with their hooks, and then migrate, usually settling in the liver and there developing into scolices. The echinococcus also infests sheep, and it is in consequence of eating their organs, which are the seat of this parasite, that dogs become the subjects of the corresponding tape-worm. Iceland is the country in which hydatid disease is most prevalent."

Having resided in Iceland for two seasons, living (?) most of the time among the primitive natives in the interior, I had ample opportunities to study their habits and conditions; so the above statements of Dr. Roberts brought back vividly to my mind one explanation why *one seventh of the whole population* of Iceland is affected with the various forms of hydatid disease.

The poorest Icelander will have his quota of dogs; and to ride up to his tun and be greeted by a lot of "pariahs" not unlike the Pomeranians, snarling, growling, and bristling, is, until one becomes accustomed to it, to say the least, not pleasant. It is through these dogs, who are continually living with the sheep, that the natives become infested with the *echinococcus*.

So evident was this fact that the Althing was induced (*magno cum risu* of the public, who asked why the cats were not also assessed), to impose an annual dog tax of \$2.00 per head upon all dogs exceeding ten in a hut.

Most authors explain the prevalence of hydatids by saying that the ova are taken into the alimentary canal of the native by eating from the same receptacle with their dogs. I admit that such is the fact, but if these authors had lived in the interior of the country they would have given an additional reason.

Among the numerous ideas and superstitions of the people of the land of "Eddas" and "Veddas," is one that a bolus made of the dried fæces of their head dog will cure all internal complaints. Now when you see an old woman giving her son or grandson a bolus the size of a hickory nut to relieve his constipation, is it strange that one-seventh of the population is suffering from hydatid disease?

They have a novel way of removing the cyst from the liver. Making a parallel incision, they grasp the walls, pass a thread through both sides of the wall, and twist the ends of the thread around a small stick; then two or three times a day different members of the family "take a turn" at the stick. In a few days the cyst and its contents are brought out and preserved among other heirlooms.

A superstition long ago obsolete was that the "lausnarstein," a flat, hard seed, two or three inches in diameter, would, when drunk in infusion, facilitate parturition; the superstition vanished when it was found to be, not a magic bean, but only a horse-chestnut thrown ashore, like the "*dolichos urens*" and the "*entada gigoalobium*," by the currents. To those who are interested in the subject of hydatids, I refer to *Schmidt's Jahrbüchen der In und Ausländischen Gesammten Medicin*, No. V, Band 134, and No. X, Band No. 152. For the Northern authorities I refer to Hjaltalin, Jon Finsen Krabbe, Thorarensen, and Skaptason.

1126 N. Calvert St.

The managers of American railroads appear to have read certain medical journals whose editors frequently lament the lack of clinical training given in the schools to medical students, and have decided that this omission on the part of the colleges shall not prevent the development of skillful surgeons. In order to supply the clinical material necessary to make great operators they mismanage and neglect the equipment of their roads till each day brings an accident, attended by loss of life and injury to numerous passengers. Unless there is an improvement in the manner of running and inspecting roller stock and examination of road beds, those doctors who are ambitious to achieve reputations as surgeons will do well to desert the hospitals and secure appointments as railroad surgeons. Some one may remark that Chicago physicians can feel assured of a full share of surgical practice while our surface roads and grade crossings remain in operation. Such a remark will provoke no argument.—A Chicago Exchange.

The thirty-seventh annual session of the Kentucky State Medical Society will be held in the city of Louisville, on May 4th, 5th and 6th. The meeting promises to be an unusually large and interesting one. Communications, with titles of papers, may be addressed to the Permanent Secretary, Dr. Steele Bailey, Stanford, Ky.

FREE DISPENSARIES; THEIR RELATION TO THE  
PROFESSION, AND TO THE PUBLIC.\*

BY S. A. KEENE, M. D., OF BALTIMORE.

Mr. President and gentlemen:—The subject that I desire to bring to your attention to-night is one not only worthy of free discussion, but one to be commended to the strongest and best efforts of the profession to make it what it should be, the beau ideal of charity and benevolence, a boon to suffering humanity, an aid and not a barrier to the general practitioner.

Free dispensaries were no doubt suggested by the philanthropy and tender sympathies of the ever kind-hearted, to condone, in part at least, the misery, suffering and disablement of the deserving and needy poor of the community. In this they are commendable, and God forbid that any effort of mine should ever be bent to rob, or detract from the alleviation of suffering humanity, or prevention of human misery and wretchedness.

My inquiry, therefore, in this matter will be to ascertain and determine how far the integrity of the original idea of free dispensaries has been maintained in the proper and just dispensation to the needy; to what extent courtesy to the medical profession has been preserved; and how much the general public has been benefited by them.

The necessity for this paper arose in my mind some months ago, when I was privileged to hear an excellent paper by Dr. Walter B. Platt on the subject, read before the Clinical Society of Baltimore and afterwards published in the MARYLAND MEDICAL JOURNAL; and I determined to bring it to the attention of this society. In doing so I shall quote right liberally from Dr. Platt, who is a dispensary physician and thus knows of what he speaks. He says "the sins of omission and commission of dispensary physicians in this and other cities have raised a long and continuous storm of denunciation, loud enough to drown the feeble sound of thanks which our best efforts call forth from the patients themselves. The sins against the true well-being of the community and the profession at large have in many cases justified all that has been said, and more."

Is there not, then, a good strong reason why the medical profession should at least inquire how it is affected by the present system of free medical dispensation? Dr. Platt says: "to do a proper work, and truly benefit the patient, the dispensary should treat only the impecunious and needy, and treat them only as long as they are without means to pay a physician. It should be a blessing and not a curse to the physicians who live in the vicinity, as well as to those who go thither for treatment."

It was certainly undoubted sincerity and honest courage that made him further express his belief "that nearly all the dispensaries in this city have been criminally negligent in treating almost all applicants without investigation."

Who is there of my hearers who cannot cite many cases of well-to-do people who have availed themselves of the privileges that were intended to be accorded solely and alone to the needy poor, and thus by consuming the time of the willing physician have prolonged the agony and suffering of the needy ones, and just so often by extending their stay added to the wants and discomforts of the desolate homes where perhaps they are the only solace and comfort.

Not content only with engaging the time of the physician, they are ever ready and willing to deplete the pharmacy, the depository of private and public beneficence, and thus rob many a poor one of that which would perhaps bring quicker and greater relief.

\*Read before the Baltimore Medical Society, April 11, 1892.

Most assuredly the hours devoted to dispensary practice should be for the poor only, so that the kindly efforts of the physician might possess the most potential and beneficial effect. There are, Dr. Platt says, "a goodly number of organic diseases, readily overlooked in the hasty way dispensary patients are often examined. Many are the cases of cardiac valvular diseases treated for malaria, while there are doubtless scores of patients upon every dispensary record with undoubted renal disease who are treated for the accompanying dyspepsia, bronchitis or diarrhœa; but where no microscopic examination of the urine has been made." This is a statement as true as honest; and who will gainsay that the very object and purpose of dispensaries are aborted? Will one longer question or doubt that oftentimes those who should be entitled to a fair and considerate examination are, if not carelessly, at least hurriedly prescribed for, and made perhaps more despondent when the anticipated relief is not secured; rendering their condition, mental and physical, more forlorn and pitiable?

So far I have attracted your attention only to the drama that is performed daily between certain hours upon the dispensary stage. Day after day the routine work goes on. Crowds form in line and are ushered before the dispensary chief, to be assigned to one or other of the physicians whose specialism would seem most likely to grasp the special ailment. Then around with a ticket, they must fall again in line to await their turn and admission before him, who, from experience, knows that in order to get through within the limited time, he must not only take in the situation at a glance, but must have all the various dispensary compounds so fixed in his mind that the mere thought will guide the fingers in pencilling the correct abbreviations.

Day after day some will return to report progress and finally obtain a discharge that gives a new lease of life; others, however, may discover that each day comes and goes and brings neither relief nor encouragement; but rather leaves on its retirement more suffering and increasing despair, until at last failing strength forbids their daily consultation at the dispensary. Then what becomes of them? They certainly must be in greater distress than before. If they cannot get their dispensary physicians, they must appeal to the charity of some neighboring physician, however hard it may be for them or him. If the dispensary is attached to some one of the colleges, I am told that one of the students is sent to look after the case, and then the poor patient in his greatest need is deprived of the skill obtained by experience, or at least guaranteed by graduation. Thus it is that life ebbs away in that poor, neglected home, with no experienced hand to apply the soothing balm, with no interested sympathetic heart to guide the departing spirit away. If this be true, what a mockery of justice, what a perversion of charity, what a reversion of philanthropy free dispensaries are! Far better would it be if they were abolished than to have the stigma of misapplied benevolence cling to them. A grander and nobler work could be accomplished by allowing the poorest of the poor to select their medical adviser, in the beginning of their sickness, from the long list of those who love their profession and believe that self-sacrifice is the best characteristic of a man and charity the purest and noblest emblem of a christian. There would be no danger that, even in this degenerate age, they would suffer from inattention.

The fame that clings to honored and respected names upon the memorial pages of our own medical history will fire the ambition of all, and particularly of us who must soon furnish records of our deeds and transmit them as a heritage to those who will survive and come after us. And thus the work will go on increasing in warmth and enthusiasm, that will perhaps encourage the indigent and neglectful

to be more industrious and provident. For, aside from administering to the ills and suffering of nature, the sphere of the doctor is broader. He must enter into the very nature of his patients; he discovers in the deepest recesses of their construction the features of their disposition. Then no one can have greater suasion in forming, modelling or remodelling their temperaments, peculiarities and moral status. For the public weal, let the poorest, the most abandoned and degraded affiliate more intimately and more sincerely with the physician. There can be no doubt that indiscriminate alms-giving breeds paupers and that the greater need of the poor, whether deserving or not, is counsel and sympathy. They need to be taught and assisted to help themselves. Who can better do this than the physician? He enters the lowly habitation and in his effort to ameliorate suffering and disease he is confronted by all the circumstances that go towards impoverishing and degrading the inmates. The adventures of his life are varied by the incidents of extravagance and luxury that pertain to the gilded and tufted palace of the rich man, down to the scenes of the poorest man's hovel. He ascends to the solon's intellectual dome and descends to the idiot's cell. He meets the successful man filled with energy, providence and thrift, and must go to him who is degenerate by the absence of such traits.

Such being the case, and assuming that he is a man of at least some observation, and further presuming that there is certainly some spirit of confidence embedded in the breasts of his patients towards him, I submit that none are better fitted to lift up and elevate the mind, however depreciated it may be, to visions of self-providence and independence.

My resume, then, is this: Dispensaries, as at present conducted, do not confine their beneficence to the class for whom it was intended, and even if they did, there is strong evidence that the proper benefit is not obtained, by reason of hasty and ineffectual examinations.

By treating patients who are able to pay at least in part for professional services they are discourteous to the profession, and rob many a worthy practitioner of that to which he is justly entitled. They withdraw from the young physician not only the advantage of the experience he would obtain by having the opportunity of treating such patients, but they deprive him of the chance of becoming enthused in his profession, by having something to do, which will give him interest, anxiety and responsibility, and allow him occasions to study human nature, which is so essential to professional success. Such advantages and privileges would afford him practical lessons for moulding his youthful mind for sacrifice, for enlarging his heart for charity; and teach him to know how to encourage and counsel to a better life by opening up better ways.

Nor do they serve the public weal, for it is quite certain that dependence is encouraged; indigence and improvidence are countenanced; fraud and imposition are sanctioned; charity and benevolence are misplaced. Thus poverty is increased, humanity degraded, and physical suffering intensified. The very evils that were intended to be modified grow greater and wider.

The remedy, then, is to abolish free dispensaries and establish in their stead provident organizations, through which their members may obtain relief by their own provisional and honest endeavors. A thousand times better would it be for the community if the man of meagre means would pay small weekly or monthly installments into a general fund that would provide for him professional service and medicine when sick and thus elevate him to a position of manly independence, than to have him grovel about indifferent, improvident, with no ambition or stimulus to help himself, and content to drink from another's cup of ill-directed kindness.

Such organizations have existed and prospered in England for over fifty years. Their provisions are the same as those upon which assessment life insurance is based. I can see no reason why the propriety, benefit and popularity of making provision for contingencies that arise before death should not be as manifest as for those that come after death.

Who will deny that there are scores of paupers to-day who are more content to eat the bread of charity than to boast of independence by the sweat of their own brow?

The best charity is that which teaches responsibility and helps those who help themselves. None should be shielded from the consequences of their own improvidence and wrong-doing. There is no true kindness in misleading a man into the belief that he can be idle and improvident and depend upon the industry and thrift of others to take care of him. One drone will absorb the surplus products of a dozen workers; but if the workers will help him to become like themselves, they will soon be rid of their burden. Charity, wisely directed, aims to put its recipient on his feet as soon as possible and to teach him manly independence.

It does not cultivate the pauper spirit by lavish assistance, but gives no more help than is necessary; and keeps always in view the aim of getting its beneficiaries away from the dependent class that they may become self-reliant and self-supporting. People who are willing and anxious to help themselves deserve to be helped, but judiciously so, that they shall be strengthened in their honorable ambition and not debased.

As for those who are really needy and destitute, there is no danger that they will be neglected. There are too many organizations of good, heaven-blessed ladies, that are well disciplined and prepared to measure out charity in abundance to quiet the cravings of hunger, to mitigate the chilling blasts of winter and to provide for the alleviation of suffering from disease. All for them to know is that there is a mission of mercy to perform, and they undertake it; if there is want and distress to succor, their willing hands are always ready. If wretchedness and misery need a comforter, they are present; the faintest whispers of pain bring them as pilgrims to its couch; and in the chambers of death they linger to wipe away the frosty dew as it gathers upon the brow, and console the hopeless sufferer with the comforting assurance that there is a home beyond the grave free from the agony of pain. They close the glazed eyes; they fold the powerless hands; they robe the dead and place the body in the grave.

1520 Druid Hill Avenue.

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### Society Reports.

#### BALTIMORE MEDICAL ASSOCIATION.

FEBRUARY 8TH, 1892.

Meeting called to order by Vice-President Dr. S. A. Keene in the chair. The minutes of last meeting read and approved. Corresponding Secretary requested that members who have moved would please furnish their new addresses.

Drs. W. B. Clark and L. G. Smart elected members. Drs. L. Horn, A. Horn, H. K. Yeakley and M. Shanks proposed for membership; referred. Dr. Ellis's paper, owing to sickness, postponed until next meeting.

*Dr. Crutchfield* read a paper entitled ACUTE CATARRH OF NOSE AND POSTERIOR NARES,

*Dr. Reid*, in relating a case of influenza, said he did not know what had been the result with others, but he had beautiful results from calomel. When he was called in early stages and patient had rise of temperature he generally gave 10 grains calomel, followed by citrate magnesia.

Case: Young man, strong when well, son of a physician in this city. Found temperature  $103\frac{1}{2}$ , frontal headache, partially delirious; history of having come on suddenly; gave 10 grains calomel, followed in a few hours by dose of citrate magnesia. Saw him again at 10 P. M., relieved of head symptoms, temperature 101. Gave 2 grains quinia every two hours. Temperature next day normal. Mild attack of bronchitis followed, and he was confined to the house for several days.

The Dr. had lost no cases of influenza, and attributed it largely to the use of calomel, and has great faith in it.

*Dr. Ellis*, in the last epidemic, had seen his share of influenza in November and December. He had at least 100 cases and had on no occasion given calomel. He gave a cathartic when one was needed, but not calomel. The Health Department could not show a death certificate where he had given influenza as the cause of death. He had had uniform success, not by giving depressing medicines; he never gives antipyrine; acetanilid was very good and he always used it. The Dr. then commented on Dr. Crutchfield's paper.

*Dr. Crutchfield* said he would like to hear if some gentleman would give the ætiology of hay fever.

*Dr. Chambers* said he had had some experience with la grippe. One year he gave benz. soda with good results, and this year gave something else with good result. He thought the fatality of influenza as published was due to its hastening the deaths of old chronics and hangers-on.

In reference to ætiology of hay fever he did not know less about it than anything else. It was simply cooling off of skin and throwing work on the mucous membrane instead of the skin. The ætiology was difficult to prove. Proper treatment, hot baths, quinia; stay in the house. Select time for giving treatment. Large dose Dover's powder at night is very beneficial. It is self-limited in duration; you, of course, can add to comfort of patient, but he had the same amount of confidence of cutting it short as he did cutting short a case of diphtheria.

*Dr. Keene* agreed with Dr. Chambers; he thought there was nothing specific; also agreed with Dr. Reid; he fancied calomel cut disease short; he also had succeeded very well with that treatment. He had a peculiar case he wanted to relate—that of a man, æt. 40; came from office Saturday; had sore throat, ached all over; ill at ease. He gave a cathartic and gargle. Pulse 86; throat was much better next day; Monday it was also much better. Tuesday, he sent for the Dr. early, who found temperature up, and was covered with bright red-flannel colored eruption. Dr. was alarmed; treated expectantly 48 hours; desquamation and exfoliation took place; had given no medicine to produce this eruption. Three children were in the house, age 12 to 22, but none were ever sick from it.

*Dr. Ingle* was very glad the Dr. had spoken about the eruption of la grippe, as he had heard of several cases, and he recited a case of a child having had an attack of scarlet fever, and diagnosed by another physician as grippe with eruptions; had called in Dr. Atkinson for consultation, who agreed that the child had scarlet fever.

*Dr. Keene* said he had not a doubt that the Dr.'s case was scarlet fever, but his case was a grown person,

A similar case was described by Dr. Geer.

Papers announced for next meeting: "Influenza," by Dr. Ellis, and a paper by Dr. Harry Friedenwald. The meeting then adjourned.

EDWIN GEER, M. D., Rec. Sec'y.

## GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

### MARCH MEETING.

The President, Dr. Wm. E. Moseley, in the chair.

*Dr. L. E. Neale* read a report of two cases of SARCOMA OF THE OVARY.

*Dr. J. Whitridge Williams* read a RESUME OF DOEDERLEIN'S WORK ON VAGINAL SECRETION:

In view of the great interest which attaches to the question of puerperal sepsis in general, and auto-infection in particular, I thought that it might be interesting to give a brief resumé of an important work, on the vaginal secretion, which has just been published by Doederlein, of Leipzig.

The object of his work was to find what constituted the normal vaginal secretion and its relationship to puerperal troubles.

He states that to find the normal type of vaginal secretion, we must go to very young virgins, who are unaffected by any disease, and if we find a similar secretion in older women, and especially in pregnant women, we would be justified in considering it the normal vaginal secretion, and anything that differed from it, pathological.

Accordingly, he found the normal vaginal secretion to be a small quantity of a whitish, crumbling material of the consistency and appearance of curdled milk; it contains no mucus, and its reaction to litmus paper is always intensely acid.

The pathological secretion, on the other hand, is of a yellowish or greenish yellow color and cream-like consistency, and often contains gas bubbles or particles of mucus; its reaction is weakly acid or neutral, and sometimes alkaline. Under the microscope, the normal secretion is found to consist entirely of vaginal epithelial cells and a large quantity of large bacilli; while the pathological secretion consists of epithelial cells, many pus cells and a mixture of all kinds of micro-organisms.

In all, he examined the secretions of 195 pregnant women, and of them 55.3 per cent. had normal and 44.5 per cent. pathological, secretions.

As primiparæ have generally been less exposed to infection of all varieties, it would appear, *à priori*, that more of them in comparison with multiparæ would have normal secretions, and this was found the case; for the secretions of 65.7 per cent. of primiparæ and only 38.6 per cent. of multiparæ were found to be normal. Naturally, in private practice the proportion of normal to pathological secretions would be far more favorable.

The point of greatest interest in his work is that he found this bacillus constantly in the normal secretion, and not in the pathological ones. The bacillus does not grow upon the usual culture media, but can be readily cultivated upon sugar bouillon and agar agar. It was found to produce an acid, which he considers lactic acid, with great rapidity, and it is to it that the normal acidity of the vaginal secretion is due. The products of the life of this bacillus appear to be fatal to the growth of most of the pathogenic organisms, as he showed by experiments. Thus, he could introduce large quantities of pus-producing organisms into the vagina and in four days find that they had completely disappeared. It was shown by experiment that the bacilli were not pathogenic, and therefore that



it could play no part in the production of sepsis. Accordingly, in more than one-half of all cases there could be no possible danger from sepsis, unless it was introduced from without, and even then, unless very large amounts were introduced, they would be rendered innocuous by this acid-producing bacillus.

The pathological secretion possesses marked pathogenic properties, as was proved by innoculating 18 rabbits with it, in all of which suppuration was produced, and in some instances death. This secretion contains all sorts of microorganisms, and in 8 out of 87 cases, streptococci were found.

As the streptococcus is usually the cause of puerperal fever, and as the other pus organisms have not as yet been shown to play any part in its production, we may conclude that even the pathological secretion is only dangerous in about 10 per cent. of the cases, and that in about 90 per cent. of all women, whether the secretions be normal or pathological, there is absolutely no danger of auto-infection; in these cases, therefore, there can be justification for internal disinfection.

Doederlein does not consider that the streptococci are able of themselves to invade the uterus and produce infection, and accordingly believes that the only way in which they could gain access to the uterus, even if they were present in the vagina, is by being carried there by manipulations of one sort or another. Consequently he considers that any examination whatever in these cases increases the danger of infection, and it is most likely that, under these circumstances, vaginal injections do more harm than good.

In the light of these observations, the examination of the vaginal secretions is made a part of the routine practice at the lying-in hospitals at Leipzig, before the students are allowed to examine the cases. If the secretions be normal, they are allowed to examine them; but not if they be pathological.

In the cases in which the secretion was pathological, he sought by various means to bring it once more to the normal consistency during the pregnancy; and, of all the means which he employed, found that injections of one per cent. solution of lactic acid gave the most satisfactory results. For it apparently offered an unfavorable medium for the growth of the pathogenic organisms, and at the same time produced the most favorable conditions for the growth of the vaginal bacilli, which in turn made the vaginal secretion unfit for the growth of most organisms. In numerous cases, under its use, he saw the other organisms give place to the normal vaginal bacilli, and the pathological to the normal secretion.

712 N. Howard St.

WILLIAM S. GARDNER, M. D., Secretary.

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#### THE TOXICITY OF THE BLOOD IN CASES OF ACUTE SUPPURATION.

Nissen reports a number of experiments in which the blood of persons suffering from suppuration was injected subcutaneously and into the peritoneal cavity of mice. In all cases blood from patients in the same clinic, but without suppuration, was injected as a control experiment, but in none of these cases was any effect produced upon the mouse. From the patient with suppuration, the blood was taken from a part of the body distant from the seat of the pus. In most of the cases, the mouse died within from two or three to twenty-four hours, after a series of characteristic symptoms. After death, the mice showed hæmorrhagic exudations, hepatization of large portions of the lung, enlargement of the spleen, and other indications that the injected poison may have been fatal by its action upon the blood of the animal.—*Boston Med. and Surg. Journal.*

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**THE MARYLAND MEDICAL JOURNAL.**

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

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BALTIMORE, APRIL 23, 1892.

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### Editorial.

#### A PRIVATE SUGGESTION TO SUBSCRIBERS.

We hope it is evident to our subscribers that an earnest effort is being made to place our JOURNAL among the very best in the country. Our "Original Article" column contains a large share of the best work done by Baltimore physicians, and also many papers from physicians of prominence in different parts of the country. Our "Medical Progress" column presents abstracts thoughtfully made by the editor from the best original articles published in foreign and domestic journals. We seek, first, to furnish in our pages only first-class information of general and clinical value to the practitioner; and second, to promote in every way the interests of the *Medical Profession* as a great guild or brotherhood of men devoted to the advancement of noble ideals and the promotion of personal and public health.

We are informed by our publishers that while the large majority of our subscribers have shown their appreciation of our journal by prompt payment of their subscriptions, some continue to profit by its receipt and perusal without making any pecuniary acknowledgment. As we are convinced that in many such cases their failure is due to those careless business habits which ruin the career of so many excellent practitioners, we would urge them to inaugurate a new era of exactness (which will eventually bring success) by sending, *at once*, remittances for the amount due, whether *small or large*.

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#### SOME MORE FACTS ABOUT THE "BACILLUS DIPHThERiÆ."

Every thoughtful physician watches with interest the progress of bacteriology, as it touches the problems of the nature and origin of disease. It is becoming more and more certain, however, that the researches of the bacteriologist are leading him further than the practitioner can afford to follow him. The ordinary physician must sit down and wait in patience until the bacteriologist has learned enough about disease-processes to be able to express his knowledge in

simple terms and to devise (if this indeed be possible) simple and handy methods for the recognition of the particular organisms which are believed to characterize each disease-process.

The conservative tendency of the family practitioner, which is doubtless often viewed as stupidity by the ardent scientific physician, has been abundantly justified by the later developments of clinical bacteriology. Had the great mass of practitioners followed rashly and blindly the apostles of germicide therapeutics, many more lives would have been sacrificed to the theory that micro-organisms must be destroyed upon the inward surfaces of the body and in its tissues by applications and doses of poisonous drugs.

About the time that the antiseptic theory began to penetrate the obtuse minds of the mass of practitioners, it was shown that it was extremely imperfect, because it gave a subordinate (and not a chief) place to the tissue cell as the great protector against disease. If, now, science will discover the importance of the secretions and excretions of the body in the shutting out and washing away of disease agents, we shall be back about where our fathers were as far as intelligent therapeutics is concerned.

To use a botanical simile, we shall still have to learn to root out and keep down the rank weeds of disease by the methods our fathers used, although we shall know more of the botanical classification and of the shape and manner of sprouting of their seeds.

By-and-by we shall come to realize that the patient must be treated at the bedside as a great integral organism, instinct with life-forces and spiritual energies, which must forever elude laboratory detection.

But to return to our subject: we were much disappointed on learning that the gonococcus, on which we built our diagnostic faith and risked the reputations of our patients, had a "double," or several of them, which were harmless and chaste and yet were liable to be mistaken even by the expert microscopist for the germ of ill repute.

Now the news comes to us in the *Lancet* of March 12th, that several eminent workers are disturbed in their minds in regard to the way the "Bacillus Diphtheriæ" has been acting. It has been found in benign fibrinous rhinitis. At least, according to present methods, the patient is liable to be dead before the long processes necessary to distinguish the simple from the malignant germ are ended.

As Virchow is said to have remarked: "The anatomical term diphtheria embraces far more than the disease evoked by the diphtheria bacillus; and a croupous exudation may be caused by the latter, as also by other agencies."

Can it be that the diphtheria bacillus is in itself harmless, and can only injure when the patient is (to use an old-fashioned expression) "run down;"—when the blood has deteriorated, or the body cells have lost their vigor, or the nervous system is depressed, or the great intangible forces which dominate the mind and thoughts are out of gear? Shall sunlight and exercise, house sanitation and fresh air, mental recreation and refreshing sleep, nutritious food and sound digestion,

still for a while keep their places as the great safeguards of the body against diphtheria?

### Reviews, Books and Pamphlets.

*Diseases of the Throat, Nose and Ear.* A Clinical Manual for Students and Practitioners. By P. McBRIDE, M. D., F. R. C. P., Edin., Surgeon to the Ear and Throat Department of the Royal Infirmary; Lecturer on Diseases of the Throat and Ear in the Edinburgh School of Medicine. With 38 colored illustrations from original drawings. Philadelphia: P. Blackiston, Son & Co., 1892. Octavo, cloth, \$7.

By dint of exclusion of dissertations on anatomy, which the reader will find in his text-book on anatomy, the author has secured room for the consideration in one handy volume, in good, large type, of the subjects necessary to a working knowledge of diseases of the throat, nose and ear. The most common, and so most important, disorders receive most discussion. The book is well worthy of consideration by those who need a practical work upon diseases of these important organs.

*The Pathology and Prevention of Influenza.* By JULIUS ALTHAUS, M. D., M. R. C. P., Lond., Senior Physician to the Hospital for Epilepsy and Paralysis, Regents Park. New York: G. P. Putnam's Sons. 1892. Price 75 cents.

In this book of 64 pages the author purposes to show that the symptoms of influenza are due to a chemical bacillus-secreted poison, with special affinity to three separate centres of the brain and cord corresponding to the three forms of the disease—the nervous, the catarrhal and the gastro-intestinal; that an antidote is formed spontaneously from the blood, which neutralizes the poison, and tends to produce self-limitation of the disease; and that the nearest approach to this antidote is the common vaccine-lymph, the proper preventive in case of a future epidemic being public vaccination.

*Lessons in the Diagnosis and Treatment of Eye Diseases.* By CASEY A. WOOD, A. M., M. D.; formerly Clinical Assistant, Royal London Ophthalmic Hospital; Professor of Ophthalmology, Post-Graduate Medical School, Chicago, etc. Pp. 146. With numerous wood-cuts. Price 25 cents. George S. Davis, Detroit, Mich., 1891. (Physician's Leisure Library.)

The purpose of this manual is to aid the physician to detect and treat, by means always at hand, those diseases of the eye which experience has shown to be most frequently overlooked in the course of general practice.

*The Uses of Water in Modern Medicine.* By SIMON BARUCH, M. D., Attending Physician to the Manhattan General Hospital and New York Juvenile Asylum, etc. In two volumes. Volume I, pp. 115. George S. Davis, Detroit, Mich. Price 25 cents. (Physician's Leisure Library.) 1892.

The purpose of this little book is to introduce among English-speaking physicians the methods of hydrotherapy, worked out especially by Winternitz; and to save hydrotherapy from passing, under the undeserved name of hydropathy, into the state of "innocuous desuetude" reserved for so many vaunted panaceas. The work is issued in attractive form and deserves careful perusal.

*Kemp & Co.'s Prescriber's Pharmacopœia.* (2nd edition, revised reprint.) A synopsis of the more recent remedies, official and unofficial, with a therapeutic

index and a résumé of the B. P. additions. 1890. By a member of the Pharmaceutical Society of Great Britain. Kemp and Co., Ltd., Bombay, India. (London, 84 Leadenhall St., E. C.) 1891.

This hand-book, a fat duodecimo issued by an enterprising drug firm in Bombay, is one of the most satisfactory epitomes of the pharmacopœia that we have seen. It treats in a concise yet thorough fashion not only of the well-known European and American therapeutic remedies, but also of numerous plants of India, some of them long famous as domestic remedies among its peoples. The therapeutic notes are enforced by references to leading journals and text-books.

### Medical Progress.

#### THE COMING FACULTY MEETING.

(From the preliminary circular just issued.)

The Medical and Chirurgical Faculty, now approaching its centennial anniversary, is the only society in this State corresponding in its organization and purposes to other State Medical Societies in this country. There can be no question as to the importance of an active organization which brings together, in its membership, the physicians of a State. The good work done by State Medical Societies is abundant evidence of this. In most such societies nearly all of the regular physicians of the State are members, and such membership in some States has come to be regarded as a guarantee of the status of the physician. What is needed to put our State Medical Society in line with similar organizations in other States is that the great body of regular physicians in Maryland join it and participate in its management and proceedings. Only in this way can the society become an authoritative exponent of the interests of the medical profession throughout this State.

We need in Maryland, no less than do physicians in other States, a strong and active organization of the entire medical profession. We need the incentives and the opportunities which the meetings of such a society afford for presenting and listening to the experience and observations of physicians throughout the State. We need to come together on such occasions for mutual acquaintance and improvement. We need to meet and consider, from time to time, matters of general professional interest, subjects relating to sanitation and medical legislation, and we need a body which, in its truly representative capacity, can speak with authority for the whole medical profession of this State.

“Organization” is the watchword of the day for all with common interests, in any department of work. Elsewhere the medical profession has not been slow in effecting such organizations, and with manifest benefits. If not already a member, will you not give your name and your influence to strengthening our State Medical Society? By the combined efforts of all the regular physicians of this State, it cannot be doubted that we can have a medical society representative of this State, and second, in its usefulness and contributions to medical progress, to none in this country.

#### HOW TO BECOME A MEMBER OF OUR STATE MEDICAL SOCIETY.

The approaching Annual Meeting of the Medical and Chirurgical Faculty in Baltimore, beginning on Tuesday, April 26th, 1892, continuing about four days, which you are cordially invited to attend, affords a convenient opportunity for applying for membership.

The annual dues for those residing in Baltimore are five dollars, and for

County members, two dollars. The initiation fee is five dollars, the payment of which exempts the candidate from dues during the first fiscal year of his membership. Printed forms, to be filled out by applicants for membership, will be sent, upon request, by the treasurer, Dr. Wm. F. Kemp, 305 N. Greene St., the Recording Secretary, Dr. G. Lane Taneyhill, 1103 Madison Ave., or the Corresponding Secretary, Dr. Joseph T. Smith, 1010 Madison Ave.

#### THE MEDICAL EXAMINING BOARD.

The late General Assembly enacted a law to regulate the practice of medicine in this State, which has been signed by our judicious Governor. This law delegates to this Faculty the authority to appoint the regular physicians on the State Board of Medical Examiners, and it is important that every regular practitioner in the State should avail himself of the opportunity to vote in the selection of these Examiners.

#### THE ADDRESSES; AND THE BANQUET.

The committee on banquet and reception, of which Dr. T. A. Ashby is chairman, are leaving nothing undone that will add to the success of the meeting. A complete program will be printed, giving a list of papers to be presented, and the order and hours in which they will be read. Unless the business of the convention should compel a change, the oration by Dr. F. Lange, of New York, on "the pathology and treatment of acute spontaneous osteo-myelitis" will be delivered on the night of the banquet, Thursday April 28th. From the titles of papers to be presented, we can promise that the session will be both interesting and profitable. Among others who will read papers the following have been announced: Drs. Wm. Osler, H. M. Hurd, Robt. W. Johnson, L. McLane Tiffany, S. T. Earle, S. K. Merrick, L. E. Neale, E. F. Cordell and C. Hampson Jones. The subject of the "President's Address" by Dr. Wm. H. Welch, has not yet been publicly announced.

#### RESUSCITATION BY PERITONEAL TRANSFUSION.

In the *Montreal Med. Jour.*, February, 1892, Dr. Johnson Alloway gives a graphic description of a case of this kind as follows:

The patient, who was ascitic, had just had her ovaries removed. All went well until about eight hours after the operation. I was then summoned by the nurse, who said the patient was pulseless and in a state of collapse. I found her in a very strange condition. There was not present that collapse we see from hæmorrhage, but a restless, sighing, semi-incoherent condition. The radial pulse was a mere flicker, could not be counted, and the heart was evidently strained to its utmost to recover balance. I used hypodermics of brandy and also of ether with extract of digitalis, but no effect whatever was experienced on the heart during the half hour I awaited a change in the pulse; on the contrary, it was gradually becoming less perceptible at the wrist. The yawning and sighing became more frequent, she became very restless in the bed, the respiration, from being very shallow, became gasping, and, in short, she was rapidly passing into a dying condition. Recognizing the fact that this alarming condition was most probably due to the sudden withdrawal of so large a quantity of fluid (three gallons) from the abdominal cavity, and thereby removing firm and constant pressure from the heart and large abdominal vessels, the patient was in fact bleeding to death within her own vessels. The remedy was evident, and without another moment's loss of time I transfused about three quarts of sterilized salt solution (temperature 110°) into the abdominal cavity, through the glass drainage-tube fortunately inserted at the operation. When I had transfused this quantity she began to scream and vomit violently. I removed the tube and closed the opening

by firm packs of cotton-wool. The strange, and I may say marvellous, result of this procedure now became apparent. The pulse at the wrist was beating full, strong, and counted 110 per minute. The time between the extreme state of collapse described and the taking of the pulse after the transfusion could not have been, at the outside, more than five or six minutes. I do not therefore think this remarkable change was brought about altogether by absorption of the salt solution, but in great part by the mechanical effect of pressure upon the vessels and heart, especially the latter, by lifting the diaphragm upwards. The heart beat did not average more than 115 during the following three weeks she remained in the hospital. The temperature rose to 101.5° next day and was afterwards normal.

The result of the peritoneal transfusion was certainly very interesting. Death in these sad cases from shock after exhaustive hæmorrhage directly the patient leaves the operating table is by no means rare. We do not hear of them all, because they are not reported, and we can therefore form only an approximate idea of the real mortality. Enemata of salt solution and hypodermic injections of the same have been tried with good results, but both of these methods are slow and limited in regard to the amount of solution which can be used in a given case. Peritoneal transfusion has not these disadvantages. The marvellous rapidity with which the fluid passes into the circulation will immediately resuscitate a failing heart, and place the patient from a dying to a living condition. In all cases where large tumors have been removed from the abdomen, the cavity should be filled with sterilized salt solution, and experience will show its great value during convalescence. I observed also that my patient did not suffer at all from the distressing thirst so noticeable after operations, and attributed so much to the effects of ether instead of the blood-loss. It is certainly a strange way of giving a patient a drink, but, notwithstanding, it is equally as safe as the usual method, provided the solution is sterile and the operation has been strictly aseptic in technique.

#### NERVE-STRETCHING IN NEURALGIA.

After relating three cases which had come under his observation, Dr. James Stewart, of McGill University (*Montreal Med. Jour.*, February, 1892) says:

In the three cases reported we had complete relief, lasting in one for fourteen months, in another about twelve months, and in the third for four months. These results, although not of a very enduring character, still are sufficiently pronounced to much more than counterbalance the slight danger and distress attending the operations performed. In each case the patient would willingly have purchased even a few weeks relief at greater cost.

A large number of cases of trigeminal neuralgia treated by nerve-stretching have been reported, but, unfortunately, the vast majority of these reports are worthless as an aid to settle the question as to the permanent value of the operation. It is very exceptional to find a case of nerve-stretching reported where very marked or complete relief has not taken place, and as the great majority of these cases are reported within six months after the operation, they go to swell the list of alleged completely successful cases. There is no doubt, I think, that the great majority of these relapse, are not again reported, and erroneous conclusions as to the success of the procedure are drawn.

I have endeavored to obtain the result of nerve-stretching in all those cases in which the state of the patient was reported nine months and upward after the operation. It is surprising how few cases observed for this length of time are obtainable. Fully 90 per cent. are reported before six months have elapsed. In

Dr. Chandler's and Prof. Agnew's collections, with the exception of one case, the longest time a patient was under observation was seven and a half months.

I have only been able to find a record of eleven cases in which the observation of the patient extended beyond nine months, exclusive of the cases I have reported. Mr. Walsham, of St. Bartholomew's Hospital, reports three cases of complete relief, lasting three years, fourteen and thirteen months respectively. Grainger Stewart reports one that remained well one year after, and the late Mr. Spence reports one nine months after operation still free from pain. Lefort reports one case where relief lasted more than one year, and Lagrange three extending over three years, one extending over two years, and one over eighteen months.

It would be very interesting to have a report on all cases operated in from one to two years after the operation. There is no reason to doubt that the percentage where permanent relief is obtained is very small, probably not more than five per cent. It is contended by some surgeons that the relief obtained is not sufficient to counterbalance the annoyance of the operation to the patient. In judging this question, we must take into consideration the fact that in the great majority of cases we obtain marked relief for a few months, a relief which is a great boon to the distressed patient; and further, the operation can be repeated with the probability of a continuance of relief. If repeated nerve-stretching fails eventually to give the relief demanded, other but more severe operative measures can be resorted to; but the operator should wait some time, as relief does not always immediately follow operation, but comes after an interval. If the pain is not wholly and always in one branch, several branches should be stretched.

#### THE NATURE OF ANGINA PECTORIS.

In the *Medical News*, March 26, 1892, Dr. Bixby, of Illinois, who has since fallen a victim to this disease in its chronic form, put the question thus:

What is it? For years the question has been asked, and as yet it is practically unanswered. The diversity of opinion as to the nature of the affection is illustrated by the number of names that have been given it, twenty-four in all, based upon phenomena that seemed to be characteristic. The common name, angina pectoris, is as unmeaning as any.

From a clinical standpoint there seems but little if any advantage in considering the affection under the two forms, true angina pectoris (in which there is disease of the heart) and false angina (in which there is no recognized heart-lesion.) I might say that no clinical distinction can be determined; and the pathology of the disorder is at best uncertain. It is true that in some cases in which death has occurred, in one, ossified or obliterated coronary arteries have been found; in another, fatty degeneration of the heart; and in another, some other morbid condition; but similar lesions are found in cases in which there had never been attacks of angina. The affection has been considered as a neuralgia, but pure and simple neuralgia it cannot be; for while neuralgia is strictly a nerve-pain (and pain enough there is in angina), the pain is so different from the indescribable, agonizing sensations of angina pectoris that the latter must be looked upon as a neurosis; and here we have a clear, decided statement that we are lost. So we accept the neuroses as the category into which angina pectoris falls, and qualify it further by the prefix vasomotor. Some writers prefer to call the disorder angina pectoris when there is recognized organic heart-disease, but under all other circumstances to call it simply a neurosis. This seems like a distinction without a difference, for with or without heart-trouble the affection is a neurosis, the heart-trouble having no clinical significance.



The pallid skin, indicative of disturbed circulation, the slowed or irregular heart's action, accompanied by pain in the thoracic respiratory muscles, seem to point more surely to a centrally impeded or deranged innervation affecting the capillaries than to organic heart-disease. With this conception we can understand why the symptomatic phenomena may be irregularly produced, one part affected and another not, accordingly as a greater or smaller number of vasomotor nerve-centres is disturbed. We also find that angina pectoris may result from organic or functional irritation of the terminal filaments of the pneumogastric nerve supplying the heart, lungs, liver, stomach, or intestines, the sense-impressions being conveyed to its nucleus in the medulla and communicated to the vasomotor nuclei. The vasomotor centres being distributed throughout the cord, as well as in the medulla, are irritated, whether from nutritive defect or otherwise, the direct cause being conjectural; the capillaries of those parts or organs from which the disturbance emanates are contracted; the blood-pressure is increased and the circulation is diminished, as indicated by the visible signs. The disturbance of circulation cries for relief, and the excruciating pain becomes a landmark for the location of the organs involved, and furnishes indications for treatment during the paroxysm, as well as in the intervals between paroxysms.

#### A CATARACTOUS FAMILY.

A short time since I removed a mature cataract from the right eye of a woman forty-seven years old, who belongs to a family peculiarly prone to cataracts.

Her mother, who died seven years ago, aged sixty-eight, was blind from cataract when thirty-three years old, and was operated on with the needle by Dr. S. P. Hurlihen, the widely known surgeon of Wheeling half a century since.

My patient's oldest sister was blind from cataract when about forty-five years old, and had one eye operated on by Dr. J. R. L. Hardesty, of Wheeling, now of Washington, D. C. Afterward removing to Iowa she had the other cataract extracted by a surgeon there.

Another sister, when thirty-eight years old, became blind from cataract and was successfully operated on by me on November 26th, 1884, under cocaine. So far as I know this is the first time cocaine had been used in cataract extraction. Three months afterward I operated successfully on the other eye.

A brother, who had gone through the war, left home and his whereabouts are not known. When last heard from he wrote that he had become blind in one eye, presumably from cataract.

Another brother died from exposure during the war, aged twenty-five.

A sister died of typhoid fever when young.

The only other member of the family is a sister aged forty-nine, who has good sight. She is the only one of the family who has reached forty who has not developed cataract.

The family, so far as can be learned, had emmetropic eyes. They were all large, well-formed, exceptionally fine looking people.—Dr. Dickey, in *Pittsburgh Med. Review*, April, 1892.

#### PERFORATION OF TYPHOID ULCER.

Discussing this subject in the *N. Y. Med. Jour.*, April 9, 1892, Dr. Elsner, of Syracuse, draws the following conclusions:

1. A localized peritonitis over or in the neighborhood of typhoid ulcer may exist without perforation.
2. Localized adhesive and protective peritonitis over or in the neighborhood of a typhoid ulcer may precede perforation and protect the free peritoneal cavity.

3. In some cases coils of intestine may become adherent, giving rise to tumor formation.

4. Symptoms simulating or approaching perforative appendicitis may exist, making a diagnosis between appendicitis and typhoid perforation with adhesions difficult.

5. Anatomical research proves conclusively that perforative typhoid appendicitis is exceedingly rare.

6. The prognosis of typhoid perforation is more favorable in proportion to the amount of circumscribed peritonitis and the nearness with which ordinary appendicitis is simulated.

7. Localized peritonitis preceding perforation and ultimate perforation can be diagnosticated in some cases.

8. Persistence of liver dullness does not preclude the possibility of intestinal perforation. Air and gas may escape into the lower abdominal regions and be held there by adhesions without changing liver dullness.

9. With effacement of liver dullness we must make sure by physical examination that such change is not due to the presence of an abnormally distended transverse colon.

10. Surgeons are not justified in performing laparotomy for the suturing of perforated typhoid ulcers if circumscribed peritonitis of an adhesive or protective character exists or is in process of development.

#### PAINFUL TOE.

An extract from an article upon this subject by Dr. L. G. Guthrie in the *Lancet*, March 19, is of interest. He says:

The intense suffering caused by this complaint, and the prompt and certain relief which may be obtained by suitable yet simple treatment, lead me to record my own experience of a special form of painful toe. Both in symptoms and pathology the complaint is identified with that to which Dr. Auguste Pollosson, in 1889, gave the name "anterior metatarsalgia." Only in the latter the metatarso-phalangeal joints are affected, whilst in the former the distal phalangeal joints are alone involved. In order to avoid a more cumbrous designation I have called the former affection, "a form of painful toe." In either case, under the influence of prolonged standing or walking in tight boots, the ligaments of one or more joints, metatarso-phalangeal or phalangeal only, become strained, slight subluxation takes place, the nerves are stretched and pressed upon by the partially dislocated bones, and the characteristic pain is produced. The pain occurs suddenly, and with a sense of something giving way at the site of the joint affected. It is relieved by taking off the boot and gently pressing the displaced bones into proper position. The reduction is always accompanied by a sharp twinge of pain, followed by instantaneous relief. I have only met with one case of the major affection. It was that of a tramcar conductor, who suddenly developed the symptoms, and had suffered from them for three months. The pain was under the head of the third metatarsal bone, he relieving by flexing his toes whilst pressing gently with his finger on the site of the pain. His occupation prevented him from carrying out this treatment as often as he desired, so I directed him to wear a boot with a very broad sole, slightly convex on the upper surface, so as to support the sunken head of the third metatarsal bone, and with plenty of room across the base of all the toes. This treatment proved thoroughly satisfactory.

The following is a case of the minor but similar affection—painful toe:—In the autumn of 1883, after a long day on duty as hospital dresser, I walked through the wet streets to the opera. The theatre was crowded, and I had to stand

throughout the performance. Towards the close I suddenly felt most severe shooting and burning pains in the fourth toe of my left foot. The boring of a hot iron into the flesh might have caused similar pain. It extended up the nerves of the outer side of the foot and leg into the sciatic, with a numbing, sickening sensation. I limped home, with dismal misgivings lest I had fallen a premature victim to gout; but on taking off my boot I discovered that the last phalanx of the fourth toe was overextended, whilst the head of the second phalanx was slightly displaced downwards. Reduction caused a sharp twinge of pain, followed by immediate relief. From this time for many months I was constantly liable to these attacks of pain, especially in hot, damp days, after standing or walking for any length of time. I learned to reduce the dislocation and obtain relief by treading heavily on the empty part of the toe of my left boot with the heel of my right, and then forcibly drawing the left foot back within the boot, at the same time elevating the toes against the "uppers." Both the displacement and the reduction were accompanied by a distinct click. This manœuvre became necessary with more and more frequency, and the pain increased in severity until I had serious thoughts of having the toe amputated or the joint resected. At last, with the happy inspiration of Mark Twain's hero, who after twenty years' confinement opened his cell door and walked out, I discovered an equally easy means of escape. My boot, though quite comfortable when first put on, became too tight across the toes as soon as the foot became at all congested. Under this condition the last phalanges became jammed and fixed together, whilst the relaxed ligaments of the second joint of the fourth toe allowed the head of the second phalanx to drop and press painfully upon the nerves. I ordered a boot with plenty of room for lateral expansion of the toes, and I was at once freed from the attacks of pain which made my life a burden.

*Remarks.*—These cases form additional links in the chain of evils attendant on wearing boots too tight across the toes. Patients will be probably loth to admit that a form of boot to which they have always been accustomed, and which they have regarded as both comfortable and elegant, can be the cause of their sudden attacks of pain. And the latter they will readily attribute to gout or rheumatism; for to the non-professional public, pain in a toe means gout, and pain elsewhere in a limb means rheumatism. Not only do the paroxysms of pain strongly resemble those of gout, but it is possible that the strained and unnatural position into which many force their great toes may account for the prevalence with which those parts become the primary seat of true gout.

#### THE EPILEPSY OF CEREBRAL PALSY IN CHILDREN.

From a long article on the surgical treatment of epilepsy, by Dr. B. Sachs, of New York (*N. Y. Med. Jour.*, February 20, 1892), we extract these remarks on the epilepsy of palsied children:

I consider it my duty to call your attention to the epilepsy associated with the cerebral palsies of children. In a paper (Sachs and Peterson, *Journal of Nervous and Mental Diseases*, May, 1890), published last year, it was shown that forty-four per cent. of all cases of infantile cerebral palsies develop epilepsy, and I have stated that there could be but little doubt that, of all cases of ordinary epilepsy, a very fair proportion were developed in connection with infantile palsies. This view has been accepted by later writers. I have seen at least half a dozen cases of epilepsy within the past year which were supposed to be cases of idiopathic epilepsy, but which, when examined carefully, revealed the traces of an old hæmi-plegia. Nor are the pathological conditions underlying these palsies properly recognized.

I would not call attention to this class of cases if we did not find among them the only cases of non-traumatic epilepsy which demanded surgical interference.

These palsies come on either in the intra-uterine period or early in life. The initial lesion in the acquired cases is generally a hæmorrhage, thrombosis, or embolism, and this focus of disease leads in many cases with rather surprising rapidity to the development of secondary sclerosis throughout the cortex. In fully ninety-five per cent. of all these cases the lesion is in or upon the cortex. The lesion—a hæmorrhage or softening, say—is very apt to be strictly limited to one or more areas. It need not, therefore, surprise us that typical Jacksonian epilepsy is found in some of these cases, or that we find scars and cysts and sclerosis just as we do in the traumatic cases.

The three cases of this class which I shall refer to were operated upon during the past year—two of them by Dr. Wyeth and one by Dr. Gerster. (We are compelled to omit the interesting notes of these cases.)

Simple trepanation seems to be more successful in these epilepsies associated with infantile cerebral palsies than in the traumatic forms, probably because of the still greater frequency of cysts in these diseases than in the traumatic epilepsies. The early recognition of these troubles is of great importance; and the question naturally arises whether we can diagnosticate the lesion with sufficient accuracy to encourage the surgeon to operate at an early day before secondary degeneration is established. I believe this will be possible in many cases, but the disease sets in frequently at a very tender age at which cerebral operations are but poorly tolerated; moreover, the epilepsy, although a probable sequel, is still a remote contingency; the paralysis represents the reality, and parents will be most apt to tell the physician to care for the present only, more particularly if looking to the future means a possible increase of the paralysis. As soon as epileptic symptoms appear, the paralysis has the value of a focal symptom; the centers should be exposed, and if not removed, they should at least be treated in accordance with the special indications of the case. In children, excision of a center is a less serious affair than in the adult, for in the former other parts of the cortex are capable to a greater degree of assuming the functions of the destroyed part. I am confident that, if these cases of infantile cerebral palsies are more generally recognized, and if we succeed in checking the tendency to epilepsy in them, the total number of epileptics will be noticeably diminished. If the surgical treatment of epilepsy be of any value at all, it is in view of the foregoing not to be restricted to the traumatic forms, but let it be applied also to those epilepsies which are associated with the cerebral palsies of childhood.

In conclusion, I would say that, under favorable conditions and by the methods described in this paper, the surgeon may be able to cure a few cases of epilepsy. He will be able to improve many, but surgeons and neurologists should in future make an earnest effort to *prevent* epilepsy.

#### GOUTY EYELIDS.

From an article by Dr. John E. Weeks, of New York (*Med. Rec.*, February 13, 1892) on several manifestations of the gouty and rheumatic states, we make this extract:

In addition to the tophi, met with in the lids of old gouty subjects, which appear as subcutaneous, pale, nodular masses, usually remaining in the tissue without producing any irritation, but sometimes producing suppuration in the surrounding tissue, we have a peculiar form of lid affection which in certain cases is one of the first pronounced signs of the gouty diathesis. This consists of a marked swelling or puffiness of the lids and conjunctiva with more or less chemosis, ac-

accompanied by a muco-watery discharge, quite annoying to the patient, and of greatest severity whenever there is an exacerbation of gout. The following is an illustrative case :

Mrs. C—, aged thirty-eight. Came on account of a marked swelling of the lids and conjunctiva, and profuse lachrymation. There was a family history of gout. The lady herself had suffered from gout in the ankle and toe-joints, and in other parts of the body for some years. The eyelids are more swollen in the morning than in the afternoon. The swelling is greatest and most troublesome during an exacerbation of the gout. The family physician reports excess of uric acid in the urine, no sugar, no albumen. The condition of the eyes when seen was as follows: Lower lids very œdematous, pale, translucent; the upper lids partake of the same condition to a less degree. Conjunctiva swollen and pale; the ocular as well as the palpebral conjunctiva being affected, there was some chemosis present. There was quite a profuse watery discharge, some photophobia, and considerable discomfort. Alkaline waters and colchicum were ordered and rapid improvement followed their use.

I have seen the patient at intervals and learn that her lids give her trouble whenever she has an acute attack of gout.

In connection with this peculiar swelling of the lids we not infrequently see a roughening, a mild form of eczema of the integument of the lids, accompanying gout.

A gentleman, a sufferer from gout, who has been under my observation for some years, has this form of lid affection. The urine shows excess of uric acid and water; no albumin, no sugar. The condition of the lids grows worse or improves, according as the manifestations of gout in other parts of the body are pronounced or imperceptible. The condition of the lids is a true indication of his general condition so far as the gout is concerned. An ointment of the yellow oxide of mercury applied to the lids controls the eczema, but constitutional treatment directed to the gouty diathesis is required to cause a subsidence in the œdematous swelling.

#### ABOLITION OF ELECTRICAL EXECUTION.

Every enforcement of execution by electricity emphasizes the objection to the method. The promises made by scientific executioners that murderers shall be despatched speedily, painlessly, and pleasantly have fallen so far short of realization that the expected reactionary protest from the outraged public shows itself in the attempt to repeal the present cruel law.

Thus far every attempt at perfecting the abominable means to the horrifying end has been a failure, and it is high time to call a halt in the revolting experimentation enacted at every execution. All the victims have been killed, it is true, but how? In every case repeated strokes were necessary, with torturing intervals for discussion and disputation among the scientific experts—the grim tussel with death timed by stop watches while the victim is writhing between scorching electrodes. The details of this dreadful business transcend in cool brutality anything that can be imagined, and yet we are assured that this is the new and improved way of doing the victim to death. How long must these sickening experiments continue before a repeal of the obnoxious law is possible? If we must have capital punishment let it be at least humane in its execution. A strong rope is always sure, is easily worked, and appeals to a higher civilization as well as to the ordinary necessities of the most primitive community.—Editorial in *Med. Rec.*

### Medical Items.

It should not be forgotten that a very excellent pharmaceutical exhibition is given, at the time of meeting of the Medical and Chirurgical Faculty, in the halls adjoining the hall of session. County physicians especially will find here many new preparations of standard drugs worth noting.

The editor of *The Medical News* wishes to obtain the addresses of all ophthalmic surgeons or physicians especially interested in ophthalmology residing in the United States and English-speaking countries of this continent. Please use postal cards addressed to the *Med. News* office, the word "Ophthalmologist" accompanying the address.

The College of Physicians and Surgeons had its graduation exercises April 14th, one hundred and thirty students receiving diplomas. Hon. Thos. F. Bayard addressed the audience. W. Wayland Frames carried off the first college prize; Charles L. Maine, the second; R. H. Powell, the third; Edward C. Applegarth, the fourth. The fourth prize man is an alumnus of the Johns Hopkins University.

Owing to the prevalence of typhus fever, the German Government has prohibited Russian Hebrew immigrants from crossing the frontier. In consequence, the Russian frontier towns have become very much crowded, and it is feared that typhus fever will spread through all of the border towns. Most of the immigrants who have been stopped were on their way to America.—*Boston Med. and Surg. Jour.*

They are curing neurasthenia (so they say) in Paris now by hypodermic injections of the sterilized gray matter of the sheep's cerebrum.

Oh! medical brother of large ambition and small practice, seize your chance to fetch out your hypodermic and get up a boom! The testicle-juice business was sadly neglected in this country; shall we let another such opportunity for fame and shekels pass unheeded?

The Medical Society of the State of Pennsylvania will hold its forty-second annual meeting at Harrisburg, May 17, 18, 19 and 20, 1892. Dr. J. H. Musser, of Philadelphia, will deliver the address on the Practice of Medicine; Dr. T. D. Davis, of Pittsburg, the address on Surgery; Dr. H. G. McCormick, of Williamsport, the address on Obstetrics; Dr. J. W. Phillips, of Clifton, the address on Mental Disorders; Dr. G. R. Rohrer, of Lancaster, the address on Otolgoy; Dr. A. A. Woods, of Erie, the address on Hygiene.

The University of Maryland School of Medicine held its commencement at the Academy of Music, April 14th. Eighty-five graduates received diplomas. The address was delivered by Prof. Randolph Winslow. The University prize and the Surgical prize were taken by J. Homer Wright; the Miltenberger prize by L. Leslie Eley; the Chisolm prize by J. Turner, Jr.; the McKew prize by Berwick Bruce Lanier and Henry Welsh Wickes. Five of the graduates were Johns Hopkins University alumni, two of them, Lanier and Wright, taking prizes.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To gook man a rare chance of making money ofered. Apply at this office, 209 Park Ave., in person or by letter.







