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THE TRI=STATE

Medical Journal ^{AND} Practitioner.

.....EDITED BY.....

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WITH ONE HUNDRED ILLUSTRATIONS.

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Vol. IV.

ST. LOUIS, MO., JANUARY, 1897.

No. 1.

ORIGINAL ARTICLES.

THE SURGICAL TREATMENT OF BRAIN TUMOR.*

By GEO. W. CALE, M. D., F. R. M. S., of Saint Louis.

SINCE operators have dared to invade the cranial cavity and the brilliant results in cerebral surgery have been published by MacEwen and Horsley in England, and Keen, Weir, Park and others in this country, the interest in brain tumors has gone beyond the diagnostic stage.

Only a few years since in these cases the prognosis was hopeless (except in syphilitic gummata) and operative treatment was entirely out of the question.

Brain tumors occur possibly more frequently in children than in adults. Following meningitis, infantile spinal paralysis and cerebral hemorrhage they are next in the list of organic nervous diseases. In adults they are less frequent than cerebral hemorrhage, embolism or thrombosis.

Starr (Brain Surgery) has published a table of three hundred cases of brain tumor, which shows the relative frequency of the different varieties of tumors in children and adults; tubercular tumors occurring 152 times in children and 41 times in adults. Sarcoma and glioma occur with almost equal frequency in children and adults.

While it is not absolutely necessary that the diagnosis should be made as to the variety of tumor present, it is certainly to be desired. Kind may modify the feasibility of an operation as will also the fact that the tumors

*Read before the Saint Louis Academy of Medical and Surgical Sciences.

may be multiple, which condition is more likely to obtain in the tubercular variety. We may also find multiple malignant metastases. It is more necessary that the location of the tumor should be defined, as only tumors in certain locations are operable: for instance, tumors located in the motor region of the brain, producing first localized spasms and then localized paralysis, or in the speech area or in the visual areas of the brain. In all such cases the diagnosis, as well as the removal of the tumor, is comparatively easy. Also tumors of the meninges, whether primary or developing in the scar following an injury. Tumors of the base and those located deeply in the cerebrum are beyond the hope of successful surgical interference. Operations for cerebellar tumors are most unfavorable in the majority of cases; of twenty-five operations for cerebellar tumors tabulated by Starr, only two gave permanent relief.

After the position of the tumor has been diagnosticated by means of localizing phenomena, it is necessary that we have a knowledge of the anatomical relation of various areas of the cerebral cortex to constant external landmarks on the surface of the head in order to attack the tumor successfully. Different authors have devised various means to this end, and I quote from Bramwell, who, I think, has given us the most thorough and exhaustive method. Of the cranium proper there are four bony prominences which are of particular value. These are: (1) The glabella, or root of the nose, which bears a definite relation to the anterior limit of the cranial cavity. (2) The occipital protuberance, or inion, which bears a similar relation to the posterior extremity of the cerebral receptacle, and to the upper limit of that containing the cerebellum, since it makes the point of junction of the falx with the tentorium. Between these two poles of the vault is disposed the whole mass of the cerebrum, and their surface distance apart, on the vertex, is definitely related to the mesial surface measurement of the whole arc of the cerebrum. With an immaterial correction for varying thickness of the skull and scalp, this mesial surface measurement from the glabella to the inion bears a constant relation to the corresponding cerebral measurement, unaffected by the varied relative expansion of the individual bones of the vault that is found to exist in all human beings. (3) The external angular process of the frontal bone bears a definite relation to the antero-lateral extremity of the frontal lobe, and to the point of origin of the fissure of Sylvius; since it marks the plane of the floor of the anterior fossa, the posterior limit of which corresponds to the interval between the frontal and temporo-sphenoidal lobes. (4) Lastly, the parietal eminence is of similar value, since it marks the point of greatest lateral expansion of the substance of the hemisphere. Of the primary fissures of the brain to be defined in their relation to the external bony landmarks, the fissure of Rolando holds first place, as around it are grouped the motor centers with which we are best acquainted. The upper end of this fissure, which joins the great longitudinal fissure of the brain, is located one-half inch posterior to a point midway between the glabella and inion, or measured from before backwards along this line the top of the fissure is 55.7 per cent. of the length of the whole line. The fissure extends downward and forward at an angle of 67° with the longitudinal fissure.

To define the location of the Sylvian fissure, a line is drawn from the external angular process of the frontal bone backwards to the inion; such a line droops a little toward the external auditory meatus in avoiding the

greater convexity of the side of the skull that lies in the direct *horizontal* route between the two bony eminences above mentioned. It usually passes over the temporal bone half an inch above the meatus, at which place it corresponds to the floor of the middle fossa of the base of the skull. This point serves as the best guide in evacuating intracranial abscesses originating in the tympanum. In front of the meatus it is above the floor of the middle fossa, and behind it runs parallel to and usually coincident with the attachment of the tentorium and the posterior half of the lateral sinus. The origin of the Sylvian fissure is located $1\frac{1}{8}$ inches posterior to the angular process on this line. From this point a straight line drawn to the center of the parietal eminence marks accurately the course of the posterior limb of the fissure. The pterion, or junction of the sphenoid with the frontal, parietal and temporal bones, is also an important landmark. From its point of origin under the great wing of the sphenoid the main line of the Sylvian fissure follows that of the squamo-parietal suture to its highest point, from which the fissure diverges upwards, continuing its course to the parietal eminence. The ascending limb of the fissure, or precentral sulcus, corresponds closely with the upper part of the sphenoido-squamosal suture, the line of which it continues upwards for half an inch, giving off the inferior frontal sulcus at right angles near its upper extremity. It should be remembered that the middle meningeal artery, after grooving the under surface of the greater wing of the sphenoid, passes on to the anterior inferior angle of the parietal and is distributed to the dura, lining the anterior and superior half of that bone. If we desire to expose the tip of the temporo-sphenoidal lobe, we should trephine below and behind the line of the artery; if Broca's convolution is the objective point, immediately in front of the same line. To define the position of the remaining sulci of the brain, the two primary fissures must be mapped out on the scalp, as already described. Then the parieto-occipital fissure will be at a point two inches behind the upper end of the Rolandic fissure; when the scalp is reflected that point will be found to be placed a quarter to half an inch in front of the apex of the lambdoidal suture. The fissure is about one inch in length, running at right angles with the great longitudinal fissure, with which its upper extremity is continuous. The intraparietal sulcus commences one inch posterior to, and at the level of, the middle third of the fissure of Rolando, having the ascending parietal convolution between it and that fissure. It runs upwards and backwards for about an inch, and then turns directly backwards, forming the lower boundary of the superior parietal lobule. Then, passing below the outer extremity of the parieto-occipital fissure, it enters the occipital, in which it terminates.

[TO BE CONCLUDED IN OUR NEXT ISSUE.]

Officers City Hospital Medical Society for 1897.—President, Joseph Grindon; Vice-President, L. C. Boisliniere; Secretary, Horace W. Soper; Treasurer, W. C. Mardorf; Executive Committee—John B. Shapleigh, Ludwig Bremer, Frank A. Glasgow; Publication Committee—H. S. Crossen, Harry M. Pierce, Wm. S. Barker; Programme Committee—Ellsworth S. Smith, Walter B. Dorsett, Wm. A. Brokaw; Entertainment Committee—Benj. M. Hypes, Jacob Friedman, Frank G. Nifong.

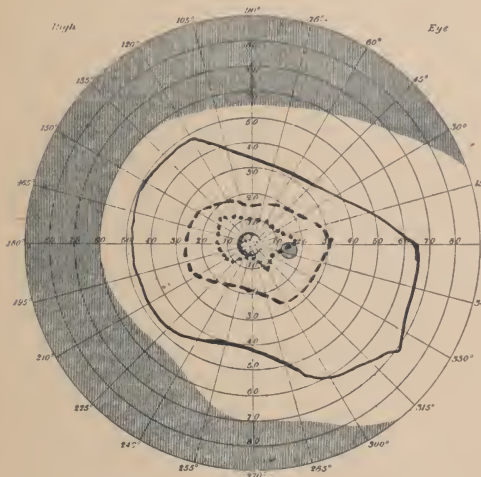
RETINAL HYPERÆSTHESIA INDUCED BY RED COLORED OBJECTS.

By W. M. BEAUMONT,
Surgeon to the Bath Eye Infirmary, Bath, England.

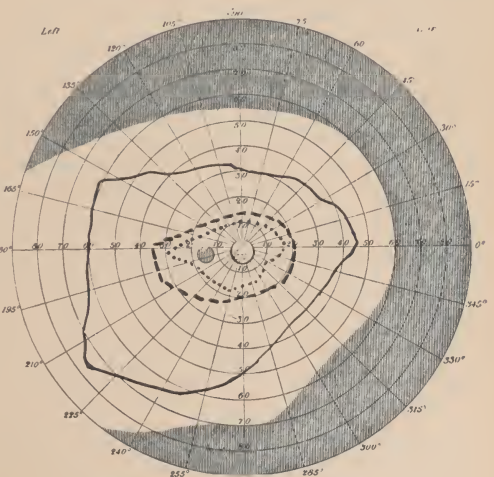
AN OFFICER in the Indian Army came to me in 1894 and gave the following history: He said that in 1860 he was stationed in a damp and hot part of India, and there noticed for the first time in his life that, although his sight was perfect both for near and distant objects when dressed in mufti, yet when in uniform, with other officers in scarlet around, his vision was blurred, and a darkness came over his eyes, making it difficult to decipher ordinary writing or printing. Later in the same year, after severe fatigue and prolonged fasting while riding under a blazing sun, he fell from his horse and lost consciousness, but recovered after having buckets of cold water thrown over him. The next year (1861) he again fell from his horse when riding, but this time without any assignable reason. He was now stationed in a dry, hot part of India, but during this year he was not in the least degree affected by the color of the uniforms, either when seated at courts-martial, or when on parade, under the blazing sun.

The following year (1862) he was stationed in a cooler part of India, and had no trouble with his eyes, except some slight accident to the right with a piece of bamboo, which left no ill-effects. During the next eighteen years he was in the habit of going out after breakfast and walking in the strong sun-light to his office, where he had some clerical work to do in a darkened room. He had some difficulty in seeing to read at first, but soon got used to the dimness, and noticed no other inconvenience. In 1880 he had another severe fall, after which he frequently noticed when walking in the sun in the morning that a transient darkness and giddiness came over him. He also observed every day during luncheon that a "darkness" came over his eyes, the cause of which he attributed to the red shawl of an old lady who lunched at the same hotel. About May, 1882, while riding past a regiment in red who were manœuvring under a burning sun, the sun and the regiment being both on his right hand, he became suddenly blind in the RE. He could not even see his hand when held up in front of his face, but on sitting down for a short time under a tree his sight returned. During this period of his life he could go out with a regiment dressed in rifle-green or blue, or kaki in the hottest sun without the slightest ill-effects. In 1883 he returned to Europe, and one day during the passage of the Red (!) Sea he was sleeping on deck under an awning, when the awning was pulled aside for some purpose. He awoke, and it seemed to him that he was being carried away in a rushing river of fire. For days there was the sensation of a dagger in his head, on the side which had been exposed to the sun. He was told by the doctor that he had had a slight sunstroke. On arriving in England he was not much troubled by red objects, with the exception of a red-brick house, opposite his own residence, when the sun was shining on it in the morning. In 1885, while sitting with his back to the window reading, he suddenly found that his sight failed, the cause of which he believed to be a piece of red blotting paper on the right hand side of the table, for on removing it, his sight

soon returned. On other occasions he had noticed that when the sun shone brightly in through the window on his right, and was reflected by the red curtains, his sight failed to such an extent that he was unable to continue reading. Wearing blue glasses or closing the eyes for a short time always brought back the power of vision. In church he had frequently been distressed by the red cushions, as well as by the red in the ladies' bonnets, especially when the sun was shining in the windows, or when the gas was lit. Since 1885 his condition had remained practically unchanged. Often when walking quietly he had been brought suddenly to a standstill with giddiness and weakness of the limbs merely by his eye being caught obliquely by the redness of a dress in a shop-window, or it might be by the parasol or red tie of a passer-by. At Bournemouth in 1892, where he went for a holiday, he found no ill-effects from the sun-light, and congratulated himself upon being able to look at red, even in the streets, without feeling any discomfort. Soon after his return from Bournemouth his troubles



Visual Field of Right Eye.



Visual Field of Left Eye.

recommended; and one day, while walking briskly, on suddenly coming into the glare of an ordinary street lamp, he became very giddy. In 1893, even with dark glasses, the bright sun, especially if there were red-colored objects about, completely upset him when out of doors, bringing on a faintness which was most distressing; but, strange to say, in the house while at rest, though the sun might be shining, he felt no discomfort. The same year he went to Eastbourne, and whilst there, he describes his condition as that of a martyr. The burning sun overhead, with the red-bricks with which Eastbourne is paved, so affected him that he could not walk without assistance. He even felt some discomfort out of doors at night with the electric light, but in the house he was as well as possible.

This, briefly, is the medical history of this highly sensitive officer, extending over thirty-four years. In the RE there are three dioptries of hypermetropia, and with the corresponding lens $V = \frac{6}{8}$. In the LE $+4D = \frac{6}{8}$. The fundus is normal in appearance in each eye. On looking at the accompanying charts—in which the outer line is the field for white, the broken line the field for red, and the inner dotted line the field for green—it will be

seen that the fields for red and green are proportionately more contracted than that for white. It is of importance to remark that he had always been a great smoker, his average consumption being nearly $\frac{3}{4}$ of an ounce daily. There was no scotoma. In the right, that is the eye which is most affected by the erythrophobia, the field for red, although very contracted, is much larger than that for green. In the left red and green fields are also very contracted, but hold a fairly average ratio to each other. Moreover, on comparing the field for red in the RE with that in the LE it will be seen to be very much larger, whereas, the field for green is exactly the reverse. The fact that the red percipient area is larger and the percipient area of the complementary green smaller in the right than in the left may explain the greater annoyance which red rays cause in that eye: there is a larger surface of retina to receive them, and consequently the effect is increased. It is, perhaps, a fortunate provision of nature which has deprived his hyperæsthetic retina of normal fields of vision.

My patient has been in the habit of wearing smoke-tinted glasses whenever the sun is very bright, and whenever he is much exposed to red rays. As he had never worn green glasses, I persuaded him to try them, but, although the tone was most grateful to him, there was this disadvantage that when he removed them and looked down on the ground under them, he was troubled by a red after-image which had the same effect on his retina that a real red object would have.

Apart from this neurosis, if such it be, my patient is in perfect health, and he is highly intelligent. Although a great smoker, he has not the classical symptoms of toxic amblyopia. His reflexes are normal, and his skin is not hyperæsthetic; nor has he any symptoms of an hysterical nature. He is not subject to headaches or neuralgia; and with the exception of one of the falls from his horse, there is nothing pointing to epilepsy. Doubtless one or two of his attacks were due to sun-stroke, but it is to be remembered that the condition which I have called erythrophobia preceded them. In conclusion, it is clear that the condition is totally distinct from erythroptia. In erythrophobia it is usually the objective red which annoys; whereas, in erythroptia the red is subjective.

Tri-Statement.—The Fifth Annual Meeting of The Tri-State Medical Society of Iowa, Illinois and Missouri, will meet in St. Louis, April 6, 7 and 8, 1897. A large number of valuable papers will be read. Dr. Joseph Price, of Philadelphia, will hold the Surgical Clinic, Dr. James T. Whitaker, of Cincinnati, the Medical Clinic, and Dr. Dudley Reynolds, Ophthalmic Clinic. Dr. G. Frank Lydston, of Chicago, will entertain the members with an original story during one of the evening sessions. The officers are:

A. H. Cordier, M. D., President, Rialto Building, Kansas City.

Hugh T. Patrick, M. D., 1st Vice-President, Chicago.

H. C. Eschbach, M. D., 2nd Vice-President, Albia, Ia.

G. W. Cale, M. D., Secretary, 4403 Washington Boulevard, St. Louis

C. S. Chase, M. D., Treasurer, Waterloo, Iowa.

The preliminary program will be published in next issue.

A CASE OF SYMMETRIC GANGRENE.*

By PHILIP SCHOLZ, M. D., of Saint Louis.

JULY 9, 1896, I was called to little Dorothea M., aged 2 years and 11 months; found her large and bright for her age, well nourished, but the first glance showed the following posture of body:

Shoulders drawn up, obliterating the neck, head inclined forward and to left side, lower dorsal and lumbar region swayed, giving the abdomen a protruding appearance; her walk slow and concise, apparently in fear of making a painful misstep. I suspected the child had had a fall or received a blow on the back, as its appearance suggested an injury to the spine, which was denied. Upon close inspection, percussion which evinced no pain and measurements which showed no deviation, I still maintained that I had a spinal injury to deal with. Additional, I found congestion of the liver and spleen with intestinal fermentation. For the latter I prescribed calomel with bicarbonate of soda in broken doses and absolute rest in the recumbent posture upon wire mattress and cotton quilts for the supposed spinal trouble. After a few days in this position the anxious expression of face disappeared, the shoulders dropped into normal position, the child was contented and, to all appearances, well. Still my conviction was a spinal injury, which was strengthened by the mother remembering that the child fell out of bed July 2d or 3d, six days before I was called. I maintained her in that position, which the child seemed to enjoy, for two weeks and two days, when the parents insisted that the child was well and should get up. I examined the spinal column; not finding tangible evidence to prove the contrary, I submitted.

The child was allowed to get up and resume its former habits, as playful and jolly as ever. Had during this time gained additional flesh and kept on doing so until the eve of October 29th, when it cheerfully greeted its father at the gate as he came home. He took the child's hand and guided it into the house, she took supper, played awhile and went to bed. In the morning the mother observed that the entire little finger of the right hand was a "blood blister." I was summoned at once (October 30th), arrived at 11 A. M., and found gangrene of the entire little finger, also well marked beginning gangrene of the phalanges of ring and middle fingers; upon close inspection gangrene of the right gluteal region, the size of a large hand, to the depth of the entire skin. Condition of child: respiration, 21, free and easy; heart's action rhythmic, and pulse at brachial artery full, at wrist a little feeble; hands cool, temperature 0.2 above normal, feet warm; appetite good, bowels and urine voided normally. Took urine home; analysis revealed no albumin or sugar; rich in urates and phosphates. Saw child following morning, October 31st; all fingers of both hands were gangreneous; also dorsum of right hand; some gangrene spots on abdomen and lower limbs, the spot on the glutei sloughed out to the depth of the skin. November 1st, in the afternoon, I saw the case in consultation with our venerable prelate, Dr. L. Bauer, who had little comfort or explanation to offer, except that it was a vaso-motor disturbance. I was to call Monday

*Read before the Saint Louis Academy of Medical and Surgical Sciences.

A. M., which I did. For the first time I found the child sleeping, her breathing was stertorous. Her parents told me that that had been the habit in her sleep of late, none of which was perceptible while awake; pupils as to size and reflex, normal, which they had been all this time, to my judgment as well as to Dr. Bauer's who paid attention to them the day before. While I examined the eyes the child awoke. In addition I noticed that the patch in the gluteal region where the skin sloughed out presented a dry, pale-red floor, or rather the fascia below could be seen clear and almost dry; the feet had become swollen and hemorrhagic spots the size of a nickel appeared on them; also transparent blisters here and there; the same on face as feet. Both face and feet had not been involved the day before.

Shortly after I left (which was about 9 o'clock) the mother went into the next room (the kitchen). After being there a few moments the mother was surprised to behold the child having gotten out of bed and being beside



Dr. Scholz's Case of Symmetric Gangrene.

her. She carried the child back to bed; and about 12 o'clock the mother noticed the audible breathing having ceased, paid closer attention and found the child dead.

Now, there never was any motor paralysis observable in any part, as evinced by the child walking into the kitchen two hours before; not even of rectal or vesical sphincters, as the child called the mother's attention to neither up to death; there was no loss of sensation, as the child wanted to scratch her body with her bandaged hands; in fact, there seemed to be an itching sensation. The child would put the wrists to her mouth and relieve the itching sensation by rubbing them against her teeth.

My prognosis to the family was unfavorable from the second visit; on this morning I told them that she could die any moment from an embolism

lodging in the valves of the heart or in the brain. So when the child did die, three hours after I left, the parents did not deem it necessary to inform me. The first notification I had of its death was the following morning at 9 A. M., when the undertaker called for a certificate, which I gave him, viz.: gangrene (Raynaud's). But I felt loath to see the corpse put away without improving my knowledge of the case. I drove to the house, found the mother, asked for the privilege of having the child (which was laid out by this time) photographed; got her consent for that; but that was not all I was after. I drove to a photographer willing to go with me for the task; drove by my office, got my post-mortem case. The photograph taken, I now approached the father, who was now present, for a post-mortem. By this time it was 12 o'clock, and the little body was to be put away by 2 o'clock. So I commenced, with the assistance of a clumsy livery-stable attaché, and, in the presence of father and mother, who were watching their indictum (that I should not rob the body of anything for fear it could not be found at the day of resurrection), I proceeded by making an incision over the spinous processes, bared the muscular layers by pushing the skin back; I could not detect anything abnormal; now, pushing the erector spinæ back, I could find no broken spinous process or lamina. I sawed through the laminæ on both sides from the last cervical to the eighth dorsal vertebræ. As I raised the spinous processes I found the canal well filled, the dural and arachnoid membrane more or less attached to the raised bone. The medulla spinalis from the last cervical to the fifth dorsal vertebra presented a peculiar aspect; where the membranes had remained it was a purplish blue, about the color of a Concord grape; where it was detached it had the color of medullary substance of the kidney to the depth of about half the cord, and tapering both ways from the last cervical to the fifth dorsal. The posterior and discolored half could be scraped away with the handle of the scalpel, below which was yellow, the most anterior portion a grayish white or normal color; I removed a short piece of the cord, against the dictum of the parents, yet in their presence, and slipped it into a sponge, for microscopical examination, wrapping the sponge in a piece of paper. While I was sewing the corpse my clever assistant very kindly cleaned the bucket with the debris, inclusive of sponge, and when I was through I found half of love's labor lost.

The liver, and especially the spleen, showed venous stasis; nothing abnormal was detectable in the kidneys; the heart and lungs I did not examine.

Now, to recapitulate and analyze the case: That the gangrene should manifest itself in the finger first is easily explained by the location of the disturbance in the cord, the brachial plexus receiving its nerve supply from the first dorsal, and even, according to some authors, from the second dorsal vertebra.

I have searched every available practice of medicine and surgery, medical dictionary and encyclopedia, but the information gained from them on this subject is very meager, running about thus: Aply described by Raynaud in 1862, Symmetric Gangrene—Raynaud, and so on, or described by Warren, who said: "It is an irritation to the vaso-motor, producing a permanent spasm of the vessels," but nowhere in books at my command could I find Raynaud's full text.

Dehio (*St. Petersburg Weekly, March, 1894*) says, in a case of sym-

metric gangrene where he amputated the fingers, enabling him to examine microscopically the neighboring tissue, he found moderate inflammation and infiltration not attended with obliteration; further he does not regard these cases as gangrene due to arterio-sclerosis; he thinks it possible that there is a central origin, probably medullary.

Well, we can readily see that this case is a vaso-motor disturbance, but the explanation how or the true pathology? I look to anatomy for an explanation. The vaso-motor system is that plexus of the sympathetic system following the vessels. The sympathetic system consists of a series of ganglia connected by nerve strands; the uppermost ganglia are situated on the anterior communicating artery, formed by the anastomoses of the two opposing carotid plexuses (the ganglia of ribs) the existence of which, however, is questioned by some anatomists. This chain of ganglia is situated on the anterior or to each side of the vertebral column, the lowermost the ganglion impar; and this system is connected with the spinal nerves, the seat of our injury.

As the anterior or motor root of the spinal nerves leaves the dura, its fibers intermingle with those of the posterior or sensory root; as soon as the now mixed nerve leaves the intervertebral foramen, it gives off the ramus dorsalis to the dorsum. A little further on it gives off the ramus visceralis or ramus communicans. The balance of the nerve continues as the ramus ventralis. Now, it is this ramus visceralis which sends a branch to the proximal sympathetic ganglia and upon the same strand non-medullated fibers from the ganglia are sent to the spinal cord. (Gegenbauer, page 929.) On account of which this ramus is by some authors called ramus communicans, and Gegenbauer's last edition, page 861, especially says that the vaso-motor system for the walls of the blood-vessels is formed by a division of the motor portion.

Now having anatomically established a connection between the diseased peripheral part and the centrally located injury, there is something which I hope the distinguished members of this Society will elucidate, viz.: Why did the pressure of this intra-dural hemorrhage spend its influence on the vaso-motor system derived from the anterior motor branch of the spinal nerve which comes from the anterior motor horn of the gray matter, that portion of the cord which seemed to be least affected, leaving the posterior or sensory branch, coming from the posterior portion of the gray matter, seemingly the most affected by the injury, undisturbed? My inference is that the local manifestation was due to paralysis of the vaso-dilators, induced by pressure upon some part of that system in the cord.

Our Next Issue will contain some papers of remarkable value. Prof. F. Massei, of Naples, Italy, will give "A Note Upon 500 Cases of Laryngeal Neoplasms." His "note" is an elaborate article. Dr. J. Mount Bleyer, of New York City, contributes "A Memoir on the Odoriferous Sense," an annual paper read before the Société Française D'Otologie, De Laryngologie, et De Rhinologie, of Paris (1896). The articles begun in this issue will be finished. There will also be timely editorials, news items, program of the Tri-State Medical Society, etc., etc.

IS QUININE A SAFE REMEDY?

By BEN H. BRODNAX, M. D., of Brodnax, La.

HERE is the record of a community of 500 white and black. The defects mentioned are traceable directly to quinine given for relief of malarial affections.

DEAFNESS: Two white women, over 30, hearing permanently injured; one most entirely deaf at 39 years old.

Five women, three men, constant roaring (like the waves on the shore in a storm) in the head.

Four children under 10, hearing impaired permanently.

EYES AFFECTED: Six white, five black; "a smoke constantly passing before the eyes;" three women and five men, *muscæ volitantes* came on several years ago after taking quinine in 12- to 18-grain doses.

TASTE: Two women, one man, lost power of distinguishing the finer flavors entirely; only the strongest salt, pepper, sugar discernable, and after taking a recent dose of quinine even these are lost—water having no taste or only a flat taste as if it had been boiled.

KIDNEYS AND BLADDER: Some fifty cases of irritable kidney causing increased secretion of urine at night; more pronounced after a recent dose of quinine.

Six persons aged 12 to 45 years, who cannot take even two grains of quinine at any time without producing hæmaturia.

Eight who cannot retain their urine more than one or two hours after lying down at night.

Hæmaturia in 1896 in the county, within my knowledge, thirty-three cases, six deaths.

A child of 3 years, on the 15th of November, 1896, having received $3\frac{3}{4}$ grains of "amorphous quinine" syrup contrary to my orders—blood passed three hours after last dose of $1\frac{1}{4}$ grains. The bowels had been opened by calomel, but not sufficiently; additional calomel and phosphate soda was given. Turpentine tea with nitre given in teaspoonful doses of the mixture, and acetanilide one-half hour before chill returns. There was *no return*. These are all of them parties who have been treated with quinine in full doses as to age to abort chills and fever. The case of the 3-year-old boy, with hæmaturia, was my own grand-nephew and is the first case of hæmaturia in my clientele in six and a half years, and followed three doses of $1\frac{1}{4}$ grains each of quinine, a (said to be) mild form of the medicine.

Quinine as "a reconstructive of the blood" has been for years advocated. It goes without saying by *those who take* quinine that the hearing is affected, taste depraved, the stomach disturbed. Through it the digestion of food is not aided—in fact, is prevented.

Is it reasonable to suppose that a medicine which cuts up such devilment in the economy *promotes good blood*, which *said good blood is the life of the body*?

Small doses *may not* produce so much trouble, but is that any recommendation? If the large doses do produce trouble and the small doses, $\frac{1}{2}$ and 1 grain, *do not* keep off the chill, but aid the heat and malaise of the

body when failing to do any good, why give the large doses? For the same reason why give the small doses?

For the combination of reasons why give it at all?

Is it a habit some have fallen into?

Is it because the books say so?

Is it because the professor says so?

Well, put these aside for awhile and find some reasonable excuse for doing that which is acknowledged by doctor and patient to be a wrong.

Quite a number of doctors have remarked to me (some in *very* forcible English) "the stuff is execrable in its effects every way. If it aborts the chill the patient is in a pitiable condition for several days, and if it does not, adds to his discomfort."

I believe this is the real "true inwardness" of every *real* doctor who *studies therapeutics* everywhere.

SUPERNUMERARY OVARIES.*

SOME REFLECTIONS ON ORGANO- AND SERO-THERAPEUTICS.

By J. B. ROSS, M. D., of Saint Louis.

BLAND SUTTON has the following remarks in his well-known work, "Surgical Diseases of the Ovaries and Fallopian Tubes," page 22:

"So far as evidence at present stands, an accessory ovary quite separate from the main gland, so as to form a distinct organ, has yet to be described by a competent observer."

Most of the cases described by Winkel and Beigel are held by him to be "pedunculated bodies so frequently found near and in relation with the parovarium. A few were probably corpora fibrosa."

Doran found, in course of an operation, a spherical body about 12 mm. in diameter, situated within the lig. ovarii. He took it first for a supernumerary ovary, but found on microscopical examination that it was a fibro-myoma. He concludes his observation by saying: "My experience leads me to believe that others may have mistaken a fibro-myoma of the lig. ovarii for a supernumerary ovary." In my case I did exactly the opposite.

Compare with the above statements the following passage in Auvard's "Traité de Gynécologie," page 208: "A côté de l'ovaire principale se rouvent parfois des ovvires accessoires, qui expliquent la possibilité de la fécondation après la castration double, complète en apparence."

Schroeder admits the existence of third ovaries, exclusive of those cases where ovarian appendices were found containing follicles. He refers to cases of Koch and Mangiegalli, especially to the one described by Winkel, where a third ovary was found in front of the uterus, connected with the latter by a proper lig. ovarii.

Ziegler remarks in his work, "Pathologie und Anatomie," Bd. II., p. 825: "Merzällige ovarien sind in mehreren Fällen beobachtet und entstehen dadurch, dass die Anlage eines Ovariums in zwei Theile getheilt wird

*Read before the Saint Louis Academy of Medical and Surgical Sciences.

oder dass von einem Ovarium mehrere Theile mehr oder weniger abgeschnürt werden.”

Permit me to quote one more author. Pozzi, p. 812, “*Traité de Gynécologie*,” says: “Il ne faudrait pas prendre pour de petits corps fibreux les ovaires accessoires, dont Waldeyer et Beigel ont signalé l’existence possible, au dessus de l’ovaire normale. Leur grosseur atteint rarement et ne dépasse jamais celle d’une cerise.”

Before I give the description of the microscopical appearances of my specimens I will shortly relate the history of the cases.

During a myomectomy on a young girl the left ovary and tube were found to be diseased and removed. I show you some specimens of each. On the right ovary was seen a pedunculated body, and, being taken for a myoma, it was extirpated. A furtive glance at the specimen will at once prove it to be an ovary.

The other case was a hydrocele ovarii. After the oophero-salpingectomy there was noticed in the lig. lat. of the other side a small flat oval body. I took it for an enlarged lymph gland. Curious to know what had caused its hyperplasy, it was enucleated. On first examining it microscopically I took it for a fibroma, but soon found it to be an accessory ovary. Tube and ovary of the other side were apparently quite healthy.

If you will examine the microscopical specimens you will find that the pedunculated ovary contains in its center an almost mature follicle. Round this one you will notice many smaller ones. A proper hilus is not present. It is represented by the pedicle, which serves as the carrier of the blood supply. In the small adherent portion cut off from the main gland you will also notice several follicles. The histological structure of this pedunculated ovary shows only minor differences from the normal gland. Its tissue is more dense and there is an absence of cicatrices.

The stroma of the third ovary differs very materially from the normal type. A casual examination would lead you to take it for a fibroma. A more careful examination, however, will reveal to you the existence of several follicles. In one of the specimens you will find one of them pretty far advanced. But I did not find any of mature proportions. A hilus is not present. The nutrition is carried on by a few adhesions. The periphery of the ovary is lined by a modified germ epithelium, only wanting at the places of adhesions. There are also some pseudo follicles and Flüger’s canals. On no place could I find any indication of a cicatrix.

Surgeons have often wondered at women continuing to menstruate after double castration. It was thought that small particles of an ovary had remained behind. A third ovary would explain the phenomenon easily enough.

Winkel examined 350 corpses and asserts having found eight times a third ovary in about 2 per cent. of his examinations.

My observation shows so evident how easily a third ovary may be overlooked. If those of you gentlemen who are afforded an opportunity of making “post-mortem examinations”—a coveted favor denied me—would pay some attention to this question a gap in our knowledge may be bridged over pretty soon.

We all are acquainted with the undesirable results that sometimes follow double castration. You are aware that experiments have been made in two directions to counterbalance the ill-effects of above operation.

Chrobak's assistant, after carefully dissecting the ovary, fastened it either in some other place of the abdominal cavity or to another portion of the body, *e. g.*, in the abdominal wall. When the animal was killed, some months later, the ovary was found to have formed nutritive connections and, although diminished in size, was still in functional activity.

I do not think that surgeons will often have an opportunity of making use of these experiments. It would be a rather rare coincidence that at the same time and place a Parro had to be performed on one patient and double castration on another. Even given this coincidence, I do not think that an ovary deprived of its physiological relations will influence the system in the desired direction. On the other hand, I take it to be absolutely useless to implant into women ovaries from an animal. It will only be treated as any other foreign body, *i. e.*, resorbed and cast off.

Since Brown-Sequard formulated in 1869 his theory of the "sécrétion excrémentielle" and "sécrétion récrémentielle" various applications have been made of the deductions therefrom. Hammond introduced in 1893 his "ovarin" as a cure for hysteria, etc. Lately there were published from Landau's and other clinics favorable results following the ingestion of ovarian extract and substance in cases where alarming symptoms followed double castration. I have no personal experience of this medication, but observations which I had occasion to make in Marseilles, France, in cases of tabes treated with orchitic fluid, and in cases of myxedema treated in Berlin with thyroid extract lead me to believe that most of the so-called good results are temporary only and sometimes due to auto-suggestion in the experimenter and therapeutic suggestion unto the patient. Allow me to make a few passing remarks on sero-therapeutics.

Dogs being considered immune to tuberculosis, Richet and Héricourt injected its serum into the thoracic cavity of rabbits inoculated with tuberculosis. Of the animals so treated 83 per cent. were saved, whereas only 45 per cent. of the best animals survived. Koch's discoveries directed those experiments into new channels. When Maragliano made known his experiments great hopes were entertained. There is no doubt that these opened up new fields. We are now in a position to vary our dosage and the composition of the substances with which we experiment. I do not deny that animal serum has great therapeutic properties, and more so when experimented upon. I am well aware that serum of healthy animals will sometimes cure long-standing tuberculous ulcers and even a case of consumption. But both would, perhaps, get well under the usual treatment. The sero-therapist is nowadays on a hunt for suitable cases, as is the ovariotomist in his sphere of work. Many a small abdominal tumor would have been carried safely to the grave without any shortage to life or great discomfort to its bearer, and many a case of so-called chronic bronchitis—actually a tuberculous affection—would have been cured under proper measures, without the employment of syringe or knife.

I cannot comprehend that any serum will cure any other disease than that with the active agencies of which it has been produced.

Marmoreck succeeded in increasing to a marvelous degree the violence of the streptococci and to produce a serum of an extremely high immunizing power. The disease he produced is a streptococchia, and not an erysipelas nor a so-called puerperal fever. All these have in common only the one morbid agent, the streptococcus. Apart from this, they widely differ

in many respects. The active principles in each disease being different, the resulting product cannot be the same.

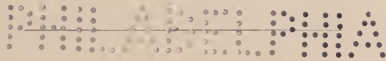
The life processes of cells forming analogous organs in different species cannot be the same. Nutrition, body temperature, occupation, temperament, etc., will influence the metabolism in many respects.

Considering this, I cannot imagine that the "sécrétion récrémentielle" of a human ovary could be the same as that of a sheep. That the "sécrétion excrémentielle" of the ovary differs in each individual case no one doubts.

That extracts of animals' organs produce decided effects in the human system is amply proved. I need only refer to the results obtained with thyroid extract in the torpid form of obesity. That ovarian extract may relieve some of the symptoms following double castration, I do not deny but I cannot see how it is to take the place of a healthy or diseased human ovary.

Time forbids to enter into detail of those interesting questions, but I hope to be soon in a position to refer *in extenso* to my researches in the field of "Sero-Therapeutics." I will then enter fully into a discussion of the physiological and biological basis of the experiments.

2001 East Grand Avenue.



LUPUS VULGARIS.

By A. H. OHMANN-DUMESNIL,

Professor of Dermatology and Syphilology in the Marion-Sims College of Medicine,
St. Louis.

THIS disease is one which is not of very frequent occurrence in the United States in comparison with the number of cases observed in Europe.

In some of the European countries it appears to be comparatively common. In this country it appears to be of unusual occurrence and even of these cases the majority seem to be of foreign origin. Such is the experience of those who have had opportunities of seeing cases of lupus, and such is the consensus of opinion of competent observers. It is chiefly in Austria, Germany, France and England that the disease occurs and it is in those countries that the most exhaustive studies on its pathology and treatment have been made. Another peculiarity in connection with lupus is the fact that Caucasians are almost exclusively the victims of the disease and it is unusual, if not rare, to see a negro affected by it. Whilst very susceptible to tuberculous infections of the viscera and bones, the negro seems to possess a certain amount of resistance to tuberculosis of the skin, and it is rarely that he presents any form of such, with the possible exception of what is known as scrofuloderma. This latter is quite common and is far from being the "scrofula" of the older authors, or of syphilitic origin, but is a tuberculous infection of the lymphatic glands which is communicated to the integument primarily through its subjacent tissues. And even here the skin proper suffers but little and heals spontaneously after the discharge of pus and caseous matter derived from the broken down glands.

The chronicity of lupus is such as to have become proverbial and it is not only chronic in nature but it is also highly destructive in its effects. Whilst many methods have been advocated as successful, it cannot be truthfully asserted that anyone is certain to be followed by an undoubted and permanent cure. Not only are relapses liable to occur in lesions; but, if these do not occur, new lesions will occur in different localities. It is beyond all question that those means are best which are most radical in their character and they are always followed by scars. When lupus cures spontaneously the result is a hard, corded scar with smooth and thin portions. In many instances the scar is stellate, the cords being disposed like the spokes of a wheel. In other instances it is a broad, pinkish scar, rather thin in places and traversed here and there by small bright blood-vessels with a tendency to become arborescent. The tendency of lupus, as a rule, is to heal at the center of a destructive lesion and for the process to extend centrifugally. Whilst this holds good in a great many instances, in others the deeper tissues become involved to the extent of producing marked destruction of the bones, eyes, larynx, etc. It has occurred more than once that the destruction became so extensive and the ravages so serious as to kill the patient. The peculiarly destructive tendencies of this disease are of so marked a character as to have originally suggested the name, *lupus*, as it ravages the tissues like a wolf does his quarry. The older surgeons did not consider even this name sufficiently expressive, so they adopted the more significant one of *lupus vorax*, or the devouring wolf. In view of the fact that their best directed efforts were attended with such poor results and as the methods employed appeared to spread the disease rather than check it, the trouble earned for itself the still more expressive title of *noli me tangere*. Under these circumstances it would seem to be a rather unpromising task to undertake the treatment of this affection, and yet the results which can be attained in certain cases seem to be sufficiently encouraging to justify an attempt not only to stop its ravages but to make an effort with a view of causing its complete and permanent disappearance.

Lupus first makes its appearance in the form of dark red macules upon the skin and these enlarge peripherally in a centrifugal manner. The patches are roundish or ovalish in form and are apt to produce pain of a more or less acute character and intermittent in nature. In a short time milletseed-sized softish nodules, situated in the lower layers of the skin, make their appearance. Later on softish tubercles appear in the patches, and these latter assume well-defined edges which are more or less elevated. A well-marked example of this particular form is well shown in Figure 1. Well-marked tubercles are shown pretty well disseminated all over the face, and the case is more than usually interesting as it is one in a negro. The nose was markedly implicated by the ulcerative process, as may be seen from the figure given. Involution occasionally occurs, as will be shown later on. More often ulceration sets in, the affected portion presenting a dirty floor. The secretion, which is rather abundant, is purulent and destruction is apparently rapid. The edges of these ulcers are rather soft and very painful to the touch. A marked peculiarity of this ulceration is that it is extremely destructive in character and it has a tendency to spread. It is not only superficially that the ulceration extends, but deeply as well. Nevertheless, there are cases in which the entire destruction goes on without implicating any of the deeper structures, and these are numerous

enough. It must not be forgotten that the peculiar softish nodules have the peculiar "apple-jelly" appearance which has been so often noted. It cannot be predicated with certainty what the size of a nodule, either in superficies or in height, will produce in the way of ulceration. It matters but little whether ulceration be superficial or deep so far as ultimate cicatrization is concerned. This follows spontaneously in both forms, the scars being generally thicker when following deep ulcerations. When this scar tissue is still young it has been observed, in some instances, that a serious condition may supervene. A malignant process may be engrafted upon it and lead to serious consequences, producing rapid and extensive destruction which, at times, is beyond all operative interference. This is



FIG. 1. Lupus Vulgaris, Tubercular Form.

another reason why the disease should not only be recognized early but treated energetically and in as radical a manner as circumstances will permit

The localities most frequently attacked by this disease are the face and adjacent parts. It is more especially the cheeks which are the seat of lupus, and females are most often the victims of the disease. The process most usually first attacks one cheek and may remain localized there. Most often it shows itself upon the other, and we have both implicated. The nose is frequently subject to the trouble and when it is the ala is the portion which first suffers. It then spreads until it implicates the whole organ, and it is found attacking the lining mucous membrane also. The destruction which ensues implicates the whole organ and destroys it completely. As an accompaniment of this it will be found that the lip often participates

on the one hand, and, by means of continuity of tissue, the eye is not infrequently implicated and destroyed. The ears are also sometimes the seat of the affection, but in these usually but one is attacked. When it is, quite a destruction occurs, reducing the size and altering the appearance of that organ. Finally, it may be mentioned that the extremities, more especially the hands, the trunk and the genitalia, are also occasionally attacked by the process. When this occurs at the outlet of mucous membranes these are very apt to share in the destruction by continuity of tissue and extension of the disease. In fact, this is constantly observed and is perhaps one of the most potent reasons for the implication of the laryngeal structures. The constant and marked pain noted in lupus is a subjective symptom of great value, as it is a feature which should serve to distinguish it from syphilitic destruction and ulceration, as well as from tuberculosis of the skin. Its intensely destructive action and the presence of more or less gelatinous nodules should further serve as prominent diagnostic factors to distinguish lupus from other diseases which sometimes resemble it and with which it might be confounded.

The subject of scars is one which, whilst of the highest interest or should be to all physicians, does not seem to have engaged that consideration which its value and importance deserve at their hands. All manners and varieties of scars have been more or less described in an equally more or less thorough manner in connection with various diseases but no systematic work on these most interesting lesions has ever been attempted. One of the reasons for this apparent neglect may be due to the fact that there has not been a sufficient amount of interest shown in regard to the matter to justify such a publication, and yet the value of these secondary lesions in the way of aiding in the formulation of a diagnosis is so great that their special study would be found both interesting and remunerative. There can be no doubt whatever that such a work, illustrated in an adequate manner, would be a valuable acquisition to medical literature and a guide of the greatest practical utility to the physician and the surgeon, not only as an index of actual disease but as a valuable adjunct in the determination of a history and thus as a help in the determination of the proper procedures to adopt and treatment to follow. More especially is this true in connection with cutaneous medicine, as every one who has devoted any attention or study to the subject will state. A scar that has peculiarities which are inherent to itself is always possessed of a certain amount of interest and those following lupus are varied and still more or less *suæ generis*. We have already alluded to the thick scar and to the stellate form. In cases in which involution takes place, as occasionally happens, small depressed or crateriform scars will occur. The pits are not very deep and yet they are sufficiently well marked to attract attention. A good example of such is given in Figure 2, the "pits" being shown at the upper part of the lupus lesion, which has existed quite some time.

These few preliminary remarks have been made for the purpose of introducing a short description of a scar which would seem to be an exception to the ordinarily accepted rule. As has been already stated, lupus will be followed by a scar which may be either spontaneous or the result of an artificial production by caustic or surgical measures. In all of these cases the scar which follows, and this is especially true of the former, has a tendency to be more or less corded, the fibrous bands which form assuming a stellate

appearance, as noted above. In some few instances, instead of a thick or corded scar, there is a thin, smooth, shining cicatrix, as is shown in Figure 3. And it is in this particular variety that care is to be especially exercised in formulating a diagnosis so as not to come to any erroneous conclusion. The following is a brief description of the case which is figured,



FIG. 2. Lupus Vulgaris, Ulcerative Form.

and it is the more interesting as it shows for how long a time lupus may persist in spite of all treatment properly directed but apparently impotent in its power to bring about a favorable result.

The patient, a man about thirty years of age, was affected with lupus when yet a boy and he was subjected to various modes of treatment, all, however, being of a caustic nature. No surgical means whatever were em-

ployed, nor was the actual cautery brought into requisition. So far as examination could determine, chemical caustics were the means used and, whilst apparent improvement followed, no permanent cure was established. At the time that the patient presented himself for treatment the entire right side of the face almost was covered by a thin scar of a more or less rosy



FIG. 3. Lupus Vulgaris, Scar.

color, with here and there a bluish tinge. Throughout the scar fine, more or less, tortuous arteries were present. The scar itself presented a more or less slightly irregular appearance, showing that it was some thinner in certain portions than in others. The right ear, which had been the seat of the disease, was smaller than the left, on account of the destruction of tissue which had taken place through a marked activity of the destructive process

which had not been checked. The lobe had entirely disappeared and the auricle gave very plain evidence of the trouble which had occurred. One very noticeable feature in connection with the scar was that the blood-vessels were much more marked and more numerous along its edges. These edges were not only of a deeper as well as darker color than the scar but were also elevated, owing to the infiltration which was present. This is very well shown in the illustration, as well as the width of the infiltrated portion. As is usually the case in such instances the edge was hard to the feel as well as painful when pressed upon. The comparatively large area involved was due to an extension of the process occurring in a more or less irregular manner. It was progressive, although slowly so; but, in a manner which seemed to defy all efforts to check it. The peculiar irregularity noted is not usual in lupus. The patient himself applied for treatment on account of the intense pain in the scar and edges and, principally, because he feared that the lupus would extend to his eye and destroy that organ, a most important consideration with him and of major interest. The pain was but of secondary importance and he attached none at all to the cosmetic appearance, being a married man.

In this case a point of more than ordinary interest connected with it was the fact that the trouble had been diagnosticated as lupus erythematosus, syphilis and tuberculosis of the skin. In the first place, the history of the case was against any one of these assumptions. Furthermore, lupus erythematosus does not produce such extensive scars, nor does it bring on such a destruction of tissue as was observed in this instance. The appearance is not at all analogous, the color being of a darker hue and there being a tendency for crusts to form rather than for ulceration and suppuration to set in. So far as syphilis is concerned there would be not only a history of former lesions, but their remains would be apparent. There would also exist concomitant lesions and the trouble would not be progressive for a large number of years without producing greater destruction of tissues. Moreover, the scar which resulted would be pigmented at first and then would become white at the center, and this white appearance would increase peripherally and the margin would be on the same general level as the integument. In addition to this, in the length of time which elapsed in this case the entire scar would be of a marked white color and there would be no blood-vessels apparent over its surface. Another point of difference is that once a scar is formed in syphilis there is no extension, whatever, of the process and in the case just given, as in cases of lupus in general, the disease extended from the edges of the cicatrix without there being any indication that it would stop unless checked by rather radical measures. It is attention to these and other details which will show how important the study of scars becomes, as well as the practical deductions which may be made by the observer of these lesions. Much help may be derived from the study of these symptoms, more especially in the way of establishing a correct diagnosis. In some future article I propose to take up the consideration of syphilitic scars and elaborate more fully upon the subject in a number of its bearings, which want of space prevents my doing at the present time.

It may, perhaps, not be amiss to state that at the present time there seems to be a consensus of opinion in regard to the cause of lupus. Many theories were advanced by the older writers and observers but, with the

accurate means at the disposal of modern investigators, more satisfactory conclusions have been reached. There is no doubt whatever that the active cause in the production of lupus is the bacillus of tuberculosis and it is not rare to find other tuberculous processes in individuals affected with the disease under consideration. There is no question, however, that there must exist a certain susceptibility in the individual to lupus before he will be attacked. It is a certain modification of cutaneous tuberculosis and, for this very reason, a certain peculiarity of tissue susceptibility must be looked for to account for its very existence. We find it manifesting itself at all ages, in various localities, the destruction being always greater in those of weakly constitutions or such as are debilitated by age, privation, etc.

The treatment is at all times a tedious as well as a difficult matter. General measures should be adopted to bring about a better condition. The nutrition should be increased to the highest possible point and every effort made to improve assimilation. The lungs should be examined carefully for any evidence of tuberculosis and the sputum carefully searched for tubercle bacilli.

Improvement has been claimed by some from the internal use of creasote, but this cannot be received as decisive, on account of the faulty reports made and of their incomplete nature. The injection of tuberculin was highly lauded for a time and apparent cures of lupus recorded, but the results were not permanent and a series of serious investigations resulted in an adverse verdict. The results obtained did not justify the use of this agent and, as a result, its use was discontinued in lupus as it has been in



FIG. 4. Author's Scarificator.

pulmonary tuberculosis. General roborant and reconstituent measures are the ones upon which the most reliance is to be placed to put the tissues in the best possible condition to antagonize the bacillus and these, with the use of proper local treatment, will bring about the best results which can be expected from the means at our disposal at the present time. No doubt better methods will be found in the near future.

The local treatment of lupus is one which presents many difficulties to the physician. There are two principle modes—surgical and medical. Among the surgical procedures may be named energetic curetting by means of Volkmann's sharp spoon. The curetting should be thorough and every portion of the tubercles should be thoroughly removed. Linear scarifications and quadrilled scarifications, as suggested by Vidal, have been found of use by many. The scarifications should be made deep, and a very good instrument for the purpose is one such as is shown in Figure 4. The blade is kidney-shaped and has a sharp edge all around its periphery. Other methods have been advocated and, in some instances, they are quite severe. Such means as electrolysis, the actual cautery, the galvano-cautery, etc., are quite severe and often necessitate the use of an anesthetic. They are all means by which nodules may be successfully removed or broken up, and an acute inflammatory process is brought about which will throw off the neoplastic growth which is present and which has a tendency to increase. After any one of these operative procedures has been terminated some strong

antiseptic application is made. In spite of the apparently radical nature of the methods relapses will follow an apparent cure after years of quiescence.

Local medicinal measures which have been employed are numerous enough and they are more or less successful. Ointments or solutions of corrosive sublimate, containing from one to two grains to the ounce, continuously applied, whilst painful occasionally, act very well. The same agent in tincture of benzoin, freely painted on the patches, is also good and productive of excellent results in some cases. Iodoform, pure creasote, sulphuric acid, pyrogallol (10 per cent. ointment) have all found favor. A method which I have found of service is the free application, twice or three times a week, of 25-per-cent. pyrozone solution to the patches. A dressing of bichloride of mercury ointment, in the strength of one grain to the ounce, should be used. This checks the spread of a patch and granulations spring up which are followed by the formation of a thin scar.

An important point in connection with lupus is to give a very guarded prognosis. It is a treacherous disease and very apt to relapse, or, in default of this, appear in some new and unexpected locality.

FORMULÆ.

Malaria in Children.—A. Zuckermann, uses the following:

℞ Tinct. eucalypt. glob.	
Spts. vini. dilut.	aa 8.0
Quin. mur.	2.0
Chinoidini	1.25 to 2.0
Acid mur. dil., q.s. ad. solut.	

M. Sig.: 20 to 40 drops five times a day.—*Esheledelnik russ., 1895, 34 (Pediatrics.)*

Formulæ for Extract of Felix Mas in Children.

℞ Extr. filicis mar. eth.	4.0
Calomel	0.4
Aqua destill,	
Sacchari albi	aa 15.0
Gelatin	q.s

M. Sig.: To be taken twice or three times.

℞ Extr. filicis maris eth.	
Tinct. vanilla	aa 3.0
Syr. terebinth.	
Aq. destill.	aa 25.0
Gum arabici pulv.	2.0

M. Sig.: One dose to be taken in milk.—*Revue Intern de Médic. et Chir. (Pediatrics.)*

Treatment of Asphyxia Neonatorum.—It is important to know whether the medulla reacts or not, as upon this fact depends the value of Laborde's recommendations for tongue traction. Schultze thinks them always inferior to cold water applications. If the child is pale, artificial respiration is the only serviceable method, interrupted every minute by a warm bath.

Hæmoptysis with Cough.—A formula given by Dr. L. G. Scarpa is:

℞ Fl. extr. hydrastis.	
Ticture hydrastis.	aa 15 grammes.
Codeine.	0.3-0.45 gramme.

M. Sig.: Take 20 to 25 drops three times a day.—*American Medico-Surgical Bulletin.*

Pruritus of the Vulva.—In cases that are not parasitic, says the *Indépendance Médicale*, M. Mussy advises the following applications:

℞ Finely powdered starch.....	300 grains.
Bismuth subnitrate, } of each	15 "
Potassium bromide, }	8 "
Calomel.....	3 "
Powdered belladonna.....	3 "

M. To be applied twice a day. It is said to give almost instant relief.

When the itching affects the inner surface of the mucous membrane, it is preferable to prescribe the following:

℞ Infusion of mallow flowers.....	1 quart.
Cherry-laurel water.....	750 grains.
Borax.....	150 "

M. To be used as an injunction twice a day. After each injection, the parts are to be smeared with an ointment.—*Medical Record*.

Amenorrhœa.—Dr. Homer C. Bloom, of Philadelphia, says, in the *University Medical Magazine*: In other cases nothing does so much good as strychnine in full and increasing doses, commencing with $\frac{1}{20}$ grain three times a day and cautiously increasing the dose. It is surprising how much of this alkaloid some of these patients can tolerate without systemic symptoms.

The following combination has given very good results in a number of these cases:

℞ Strychnia sulph.....	gr. ij.
Peptonate of iron.....	gr. cxx.
Oxalic acid (C. P.).....	gr. x.
Lactate of manganese.....	gr. cxx.
Ext. colocynth comp.....	gr. xxx.

M. ft. capsulæ no. lx.

Sig.: One capsule an hour after each meal.

Another formula given by the same author is:

℞ Oxalic acid.....	gr. iv.
Peptonate of iron.....	gr. xcvi.
Peptonate of manganese.....	gr. clx.
Elixir of curacoa.....	f℥ij.
Aqua.....	f℥vj.

M. Sig.: A tablespoonful in a glass of milk or in a wineglass of sherry-wine three times a day.

New Taniafuge Potion.—Van Aubel recommends:

℞ Amorphous filicic acid.....	gr. vj.
Ethereal oil of male fern.....	gr. ix.
Essence of cinnamon.....	gtt. x.
Gum arabic.....	ʒij.
Distilled water.....	f℥ij.
Simple syrup.....	f℥iss.

M. Sig.: One-half to be taken in the morning on an empty stomach and the remainder half an hour later. If no effect is produced within an hour or two, castor-oil should be given.—*La Médecine Moderne*.

Dacryocystitis.—In the treatment of dacryocystitis Dr. Veasey has found a solution of formaldehyde (1 to 1000) of very great service.—*Philadelphia Polyclinic*.

After-pains.—A writer in the *Journal of Medicine and Science* recommends a combination containing to the drachm:

℞ Fl. ext. cimicifuga.....	5 drops.
Tinct. belladonna-root.....	2 "
Morphine.....	$\frac{1}{90}$ to $\frac{1}{20}$ grain.

Of this the patient is directed to take a teaspoonful every five, ten, or twenty minutes, as may be needed.

Diarrhœa.—Dr. T. G. Stephens, of Sidney, Iowa, says in the *Medical World* that for an extemporaneous prescription the following is his favorite:

℞ Tinct. opii.....	ʒij
Syr. rhei arom.....	ʒiv
Tinct. catechu.....	ʒiv
Sulphocarbonate of zinc.....	ʒij
Oil of sassafras.....	mlxxx
Tr. lavender comp., q. s. ad.....	ʒxvj

M. Sig.: One or two drachms after each stool.

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STRAUS, LEON, PROCTOLOGY.

THOMPSON, G. H., THERAPEUTICS.

VOLDENG, M. N., Des Moines, NEUROLOGY.

THE PASSING OF "THE GENERAL PRACTITIONER."

We take pleasure in announcing the purchase of *The General Practitioner*, a monthly medical journal of Saint Louis, which was founded two years ago by Dr. R. C. Blackmer, and which of late has been under the editorial charge of Drs. Pinckney French, C. H. Powell and G. M. Phillips. *The General Practitioner* will be amalgamated with THE TRI-STATE MEDICAL JOURNAL, thus forming THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER. By this purchase we gain the active collaboration of the distinguished editors of *The General Practitioner*, and many new subscribers are added to our list.

A MEDICAL LIBRARY FOR SAINT LOUIS.

At last Saint Louis will have a medical library which will be owned by and conducted for the benefit of the profession. At a recent meeting of the Saint Louis Academy of Medical and Surgical Sciences that body decided to create a medical library. In less than a week several hundred volumes were donated, nearly 100 American, English, French, German and Canadian medical journals were promised for 1897, and liberal contributions of cash, book cases and other necessaries were secured. This certainly is an auspicious beginning, and it is hoped that every member of the medical profession will become interested in the movement to the extent of giving at least one volume. The library will be owned by the Academy, but any member of the profession will be given access to it. Donors will be amply

secured by a receipt, which describes the property donated and provides that in case the Academy ever dissolves the property shall revert to the original donors, their heirs or assigns. In union there is great strength, and the example of a score of young doctors in establishing a medical library for the benefit of the profession should meet with hearty approval.

THE REDRESS OF MEDICAL GRIEVANCES.

There has been another discussion regarding medical ethics in the St. Louis Medical Society. This is of interest to the writer on account of having taken part in an attempt to enforce the provisions of the code on a former occasion. This action was not taken because it was thought these provisions were, in every instance, just, or because it was thought that the code, as a whole, was perfect; but rather because serious doubts were entertained regarding these points, and it is axiomatic that the proper step to take toward the abolishment of an unjust law is to enforce it, or at least make the attempt.

Nothing, however, was accomplished by the attempted enforcement. The charges were sustained by the medical society, but it was ascertained that the jurisdiction required for the enforcement of the code was not possessed by any medical body nor would such jurisdiction be granted by the Legislature. The result, although a nominal victory for the code, was in reality a very humiliating defeat, exposing the impotency of both the code and medical associations.

For the last fifteen or twenty years many attempts have been made to have the American Medical Association amend the code in several important particulars, but without success. It has been asserted that the American Medical Association is composed largely of those who profit greatly by the inequalities in the provisions of the code; and that this accounted for the defeat of attempts to equalize its bearings; if this is true it is remarkable in showing that medical men have been submitting, in a cowardly manner, to a species of tyranny that would not be borne without a firm and vigorous protest by any other class of people; as these assertions have never been denied, they are probably true.

The practice of medicine has felt the effect of the dull times which have been prevailing since 1893 perhaps more sensibly than any affliction which has come upon the country since the Civil War. In times of distress remedies are sought after, and medical men have been seeking remedies for their own ills. The code of ethics is thought to interfere with acquiring a more extended practice, but necessity (which "knows no law") has evidently driven many into a state of obliviousness to the code's authority: hence these outbreaks, one of which recently occurred at a meeting of the Medical Society.

Perhaps one of the most exasperating observations for medical men is this: A great many physicians, in and outside of the medical society, for a long period of their practice, have been either evading the prohibitory provisions of the code or have been disregarding them. Without adopting the "quack-doctor" style of advertising themselves, they have found other means of attracting public attention and are now hailed by the people as the leading medical men of the times. If the medical society had punished the member found guilty of violating the code other doctors would

have had to show cause why they should not be treated likewise; but the unsatisfactory ending of that trial put an effectual stop to the hope of obtaining redress in this way.

The question has thus presented itself: What means have medical men for the redress of grievances within the profession? After the failure through the code, for a moment it was thought that the respect which the profession should have for its veteran members whose life-work has been a code in itself, would be an agency sufficiently potent to maintain the time-honored discipline. But upon further reflection it was seen that the rank and file of the profession regard these professional patriarchs and men of prominence who have always set the pace in medical affairs as the ones who are chiefly or wholly responsible for the worst of our medical ills.

It is argued that if these fathers of the profession had done their plain duty twenty-five years ago, the question of medical discipline would have never arisen. If the American Medical Association had taken timely steps to prevent the fatal overcrowding of the profession which has occurred, a power that this great Association could then, at least, have easily wielded, the nimbus or halo which formerly shone around members of our profession would not have been dissipated and we would have remained the master of masters instead of degenerating, as has occurred in too many instances, into being the slave of slaves.

To whom or to what shall we therefore, look for help in the day of trial?

WM. V. LOFTUS.

DEFEAT OF THE MISSOURI BOARD OF HEALTH.

In its laudable effort to raise the standard of medical education in this State and country the Missouri Board of Health has exceeded its authority. Such is the conclusion of the Supreme Court. The test case was that of Charles E. Johnson, a graduate of the Physio-Medical School at Indianapolis, who, in July, 1896, appeared before the Board, presented his diploma, offered the fee of one dollar, which the statute allows for registration, and applied for a certificate to practice medicine in Missouri. The certificate was refused upon the ground that the college granting the diploma was not "a medical institution in good standing." The Board offered to examine Dr. Johnson. He refused and applied to the Supreme Court for a writ of mandamus. In its decision, the Supreme Court said:

"Moreover, the evidence plainly showed that the certificate was refused upon that ground and the refusal of the relator to submit to an examination by the Board touching his qualifications. The President of the State Board (Dr. F. J. Lutz) testified that he found the name of the Physio-Medical College of record in the list of colleges furnished by the Illinois State Board of Health, and that list is considered standard in the United States. This would seem to settle the question as to the good standing of the college, but there was abundant evidence aside from that of Dr. Lutz to the same effect.

"Good standing as used in the statutes simply means good reputation, and must be proven in the same way. But the Board undertook to establish a rule of its own by which such good standing shall be shown, that is, by requiring all medical colleges to furnish to it a list of their respective matriculates and the basis of their matriculation, and in this went beyond the power conferred upon it by the statute from which it derives its origin, and by which its duties and authority are defined.

"While the members of the Medical Board are to be commended for their endeavors to elevate the standard of practitioners of medicine and surgery in passing, as a board, upon the applications of such persons for certificates to practice their profession, and in prescribing rules and regulations to that end, they must keep within the limits of the statute creating it, and this they did not do. As relator had a diploma from a medical college in

good standing, he was under no obligations to submit to an examination by the Board, nor had it any authority to require him to do so as a prerequisite to granting him a certificate to practice medicine in this State.

"We, therefore, shall award a peremptory writ. All concur except Judge J. Shepard Barclay, who concurs specially, as stated by him.

(Signed)

"G. D. BURGESS."

We believe in law, and the law in this case is, unfortunately, on the wrong side. It must be a source of regret to every friend of higher medical education that the Board has exceeded its powers. Such an outcome is sure to injure a good cause. It is to be hoped that future Boards will examine into their rights and powers before assuming something which is likely to be said by a court not to exist. The decision of the Supreme Court removes the Board from its position of dictator, and makes it a merely a clerical body. We hope that the present Legislature will pass a bill providing for the authority which the Board assumed, but did not have. Then in a few years Missouri will be a delightful State in which to practice medicine.

RESOLUTIONS.

TRI-STATE MEDICAL JOURNAL, St. Louis, Mo.

DEAR SIRS:—At the meeting of Linton District Medical Society, at Mexico, Mo., November 10th, the Committee on Medical Education reported in favor of the following resolutions, and its recommendations were adopted.

Resolved, That we heartily endorse the efforts of our State Board of Health to raise and maintain a higher standard of medical education, believing that it will redound to the best interest of the people and the medical profession.

Resolved, That we note with pleasure the progress made by the Board of Curators of the University of the State of Missouri (upon the advice of the State Board of Health) in establishing and maintaining laboratories for the purpose of manufacturing the various antitoxins and toxins for scientific and practical purposes, and we earnestly appeal to the Board of Curators and members of the legislature to have this work continued.

Resolved, That each member of the medical profession constitute himself a committee of one to urge upon his representative in the legislature the importance of this measure.

PETER ARNOLD, M. D., Sec'y.

DOCTOR J. MOUNT BLEYER.

Doctor J. Mount Bleyer, of New York City, whose memoir upon the "Odoriferous Sense" will appear in our next issue, will take part in the next program of the Tri-State Medical Society. He will hold a clinic for the purpose of demonstrating the value of the X-Ray in the diagnosis of thoracic diseases, and will also photograph the living human heart. The society will meet in St. Louis, April 6, 7 and 8, 1897.



Reference Book of Practical Therapeutics. By various authors. Edited by FRANK P. FOSTER, M. D. In two volumes. Vol. I. A-Myrtol. Imperial 8vo., pp. 652. New York: D. Appleton & Company, 1896. Price: cloth, \$5.00; sheep, \$6.00; half-morocco, \$6.50 per volume. Sold by subscription only.

After a careful examination of this work we have come to the conclusion that it is one of the most useful books issued by the medical press during the past year. Dr. Foster is so well and favorably known as a lexicographer and as a talented medical editor that any treatise issued under his name is accorded a respectful hearing. In the present volume we have an interesting, instructive, and complete reference-book of practical therapeutics. Not only drugs, but therapeutic measures as well, are thoroughly considered. The contributions are up to date. The publishers are justified in making the following statement:

"As instances of these characteristics of the work, reference may be made to the articles on alimentation, both in health and in disease; exercise and its effects on the muscular and bony structures, and on the physiological functions of the body; baths, their therapeutic application, including hot-air, vapor, and medicated baths; electricity, its indications, effects and methods of application; heat as a therapeutic application; hydriatics, the science and art of applying water to the human body for the cure and relief of disease, both local and general; the dangers and uses of hypnotism, etc."

The volume is issued well-bound and the paper is of good quality.

Autoscopy of the Larynx and the Trachea. (Direct Examination Without Mirror.) By ALFRED KIRSTEIN, M. D., Berlin. Authorized Translation (Altered, Enlarged and Revised by the Author) by MAX THORNER, A. M., M. D., Cincinnati, O., Professor of Clinical Laryngology and Otology, Cincinnati College of Medicine and Surgery; Laryngologist and Aurist, Cincinnati Hospital, etc. With Twelve Illustrations. One Volume, Crown Octavo, pages xi-68. Extra cloth, 75 cents, net. The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street, Philadelphia; 117 W. Forty-second Street, New York; 9 Lakeside Building, Chicago.

Doctor Thorner has made an excellent translation of a useful little book. The aim of the author can be understood by the following extract from his preface: "The fact that we have, up to this time, never viewed the interior of the larynx directly (without a mirror) is certainly not due to logical reasoning, but because we had no idea of such a possibility. Since, however, we have discovered that it can be done, and how we can do it,

there can be no possible objection raised to our making full use of our new knowledge and ability."

By "autoscopy of the air passages" the author understands the direct linear inspection, through the mouth, of the lower pharynx, the larynx, the trachea, and the entrances into the primary bronchi." The book is devoted to an elaboration of this idea. The method will no doubt prove useful.

Over the Hookah, or the Tales of a Talkative Doctor. By G. FRANK LYDSTON, M. D. Octavo, pp. 618. Price, in cloth, gilt top, \$4.00; in morocco, full gilt, \$5.00. The Fred. Klein Publishing Co., 32 Market Street, Chicago.

A delightful treat is in store for every doctor who will read Lydston's collection of smoke stories. The hookah is an Oriental pipe and these yarns are spun by an old doctor whose delight is to entertain his young friends. They are not "pipe-stories" in the newspaper sense of the term. On the contrary, they are unrivaled mixtures of grave and gay, sublime and ridiculous, polished and uncouth, true and imaginary occurrences which express as many shades and sides of human nature as were ever contained within two covers. They will chase away "blue-devils," make the discontented doctor satisfied with his lot, and are warranted to cure insomnia, neurasthenia and dyspepsia.

As a *raconteur* Lydston ranks with the best. His place in literature will probably be alongside that of Thomas Dunn English, James Gates Percival and Conan Doyle.

A Pictorial Atlas of Skin Diseases and Syphilitic Affections. In Photo-Lithochromes from Models in the Museum of the St. Louis Hospital, Paris. With Explanatory Wood-cuts and Text. By ERNEST BESNIER, Physician to the St. Louis Hospital, Member of the Academy of Medicine, President of the Dermatological Society of France; A. FOURNIER, Physician to the St. Louis Hospital, Professor of the Faculty of Medicine, Member of the Academy of Medicine; TENNESON, Physician to the St. Louis Hospital; HALLOPEAU, Physician to the St. Louis Hospital, Member of Academy of Medicine, Professor agrégé of the Faculty of Medicine; DU CASTEL, Physician to the St. Louis Hospital, with the co-operation of HENRI FEULARD, Curator of the Museum, formerly Chef de Clinique, of the Faculty at the St. Louis Hospital. Secretary: L. JACQUET, formerly House Physician to the St. Louis Hospital, Secretary of the Dermatological Society of France. Edited and Annotated by J. J. PRINGLE, M. B., F. R. C. P., Assistant Physician to and Physician to the Department for Diseases of the Skin at the Middlesex Hospital, London. Royal Quarto. Part V., pp. 113-138, with Four Plates and Figures in the Text. London: The Rebman Publishing Co., Ltd. Philadelphia: W. B. Saunders, Publisher, 925 Walnut Street, 1896. To be published in 12 parts. Price, \$3.00 a part. Sold by Subscription.

We are once more called to the pleasant task of reviewing a number of this magnificent Atlas. As the parts are issued they seem to be improving in quality, if anything. The cases which are delineated are all interesting and the same life-like fidelity to form and color characterizes each plate. The text shows the same extreme care in its preparation and the annotations of the English editor continue to be of the same value, being in many cases

valuable addenda as well as valuable in the way of explanation. We cannot help but advise this publication and can hardly understand how any physician who has had the opportunity of seeing the plates could refrain from subscribing for it and becoming a possessor of a copy of this unexcelled Atlas.

The first plate in this part (xvii) is one representing agminate trichophytic folliculitis, better known, perhaps, to general readers on medicine as Kerion Celsi. It is not such a common occurrence in this country as it is in England and on the Continent. Whether this is due to filth or neglect or both combined is a question which cannot be positively determined, for Kerion is encountered in the most cleanly. The text accompanying this plate is written by M. Sabouraud who has, perhaps, done more than anyone in connection with the subject of ringworms. He gives a most interesting account of ringworm in general, its culture and its microscopy, which is very instructive. But, as Dr. Pringle very truthfully observes in his comments, the "ringworm question" is too burning a one at the time to permit anyone to make any dogmatic assertions. It has engaged the attention of the best living dermatologists and, until the entire subject is cleared up, we will have to be satisfied with the results obtained in the researches made. The clinical description given and the plate are most excellent, especially the latter, which represents a patch on the back of the neck. Every detail is brought out with a faithfulness to details which is little short of the marvelous, and the colors are life-like and truthful.

The next plate (xviii) is a most valuable one on account of the wealth of information which it affords to even the casual looker-on. To the student it is full of details of a most interesting character and is full of instruction of a most useful character. It is a representation of lupus pernio or chilblain lupus of the face and left hand. The disease is really lupus, but the more or less cyanotic and edematous conditions are such as to greatly obscure a diagnosis and possibly lead to a mistake. As the name given to it implies it bears a great resemblance to pernio or chilblain. The case which is represented, as M. Tenneson observes, is an extreme one, and exceptional, and such as is not seen in every-day practice. This certainly makes it all the more interesting and instructive. One of the points in connection with the localization of the disease in this form—appearing in exposed parts—is very apt to confuse the observer. Mr. Hutchinson looks upon lupus pernio as a condition in which lupus vulgaris occurs in parts rendered vulnerable by a defective general circulation. Be this as it may, the condition is one of sufficient interest to warrant further study of its character, both clinical and pathologic.

One of the best plates which has appeared up to the present is the third one in this part (xix). It depicts papulo-tuberculous syphilitides of the face, many of the lesions being circinate. The reproduction of the color and the various shades, the relief which is pictured and the accuracy given to isolated single lesions make this plate a veritable masterpiece. We have seen just such cases and no truer replica could be furnished us than the plate before us. As an instructive piece of color delineation it is unexcelled. The fact that the eruption is spreading centrifugally is well conveyed by the picture. M. H. Hallopeau not only gives an excellent clinical description and history of the case represented, but he gives a most interesting chapter on the origin and nosological signification of syphilitic

local processes. Whilst rather short it is very suggestive and contains much food for thought.

The fourth and last plate in this part (xx) represents vacciniiform infantile ecthyma and simple infantile ecthyma. They are both most excellent representations of the conditions, more especially the latter. The text for both is furnished by Hallopeau. The editor remarks that similar cases have not been identified in Britain and that the name "ecthyma" is now regarded as superfluous, and is practically obsolete. This may be the case in Great Britain, but in France, this country and others it still holds its own and is employed by the best authors.

This concludes but a very inadequate notice of this excellent part and we are anxiously awaiting the appearance of the next. As in the past and like its forerunners it will no doubt sustain the excellence it has maintained in placing this Atlas in the position of the *facile princeps* of those which have heretofore appeared.

OHMANN-DUMESNIL.

Announcement.

E. B. Treat, Publisher, New York, has in press for issuance early in 1897, the *International Medical Annual*, being the fifteenth yearly issue of that well-known one-volume reference work. The prospectus shows that the volume will be the result of the labors of upwards of forty physicians and surgeons of international reputation and will present the world's progress in medical science.

The publisher states that the kind reception accorded to the *Medical Annual* has rendered it possible for him to spare no expense in its production; while the editorial staff have devoted a large amount of time and labor in so condensing the literary matter as to confine the volume within a reasonable size, without omitting facts of practical importance.

The value of the work will be greatly enhanced by the thoroughness of illustration, both colored plates and photographic reproductions in black and white will be used wherever helpful in elucidating the text.

"To those who need the condensed and well arranged presentation of the medical advances of the past year—and this class must necessarily include all physicians—we heartily commend the *International Medical Annual*."

The volume will contain about 700 pages. The price will be the same as heretofore, \$2.75. Full descriptive circular will be sent upon application to the publisher, Mr. E. B. Treat, 5 Cooper Union, N. Y.

A Practical Treatise on Materia Medica and Therapeutics. By ROBERTS BARTHOLOW, Professor Emeritus of Materia Medica, General Therapeutics, and Hygiene, in the Jefferson Medical College of Philadelphia; member of various American and foreign Medical Societies, and author of several standard medical works. Ninth edition, revised and enlarged. New York: D. Appleton & Co., 1896. 866 pages. Price, cloth bound, \$5; sheep, \$6.

It is now twenty years since the publication of the first edition of this book. The present is the ninth edition and the work has lost nothing with the progress of time. It is indeed a pleasure to read materia medica at the hands of a master like Bartholow. We predict that Bartholow's *Materia Medica* will long continue a favorite text-book.

The Medical News Visiting List for 1897. 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 160 pages of blanks. The 60-patient Perpetual consists of 256 pages of blanks. Each style in one wallet-shaped book, with pocket, pencil and rubber. Seal Grain Leather, \$1.25. Philadelphia and New York: Lea Brothers & Co.

The Medical News Visiting List for 1897 has been thoroughly revised and brought up to date in every respect. The text portion (32 pages) contains the most useful data for the physician and surgeon, including an alphabetical table of diseases, with the most approved remedies, and a table of doses. It also contains sections on examination of urine, artificial respiration, incompatibles, poisons and antidotes, diagnostic table of eruptive fevers, and the ligation of arteries. The classified blanks (160 pages) are arranged to hold records of all kinds of professional work, with memoranda and accounts. The selection of material in the text portion and the arrangement of the record blanks are the result of twelve years of experience and special study. Equal care has been bestowed upon the mechanical execution of the book, and in quality of paper and in strength and beauty of binding nothing seems to be left wanting. When desired, a ready reference thumb-letter index is furnished, which is peculiar to this Visiting List, and which will save many fold its small cost (25 cents) in the economy of time effected during a year. In its several styles The Medical News Visiting List adapts itself to any system of keeping professional accounts. In short, every need of the physician seems to have been anticipated in this invaluable pocket companion.

A Treatise on Surgery. By American Authors. Edited by ROSWELL PARK, M. D., Professor of Surgery and Clinical Surgery, Medical Department, University of Buffalo, Buffalo, N. Y. In two very handsome octavo volumes, comprising about 1600 pages, with about 800 engravings, largely original, and about 40 full-page plates in colors and monochrome. Volume I., General Surgery and Surgical Pathology. Volume II., Special Surgery. Price per volume, cloth, \$4.50; leather, \$5.50. Net. Lea Brothers & Co., 1896.

In the preparation of this treatise the assistance of the following twenty-eight surgeons has been invoked: W. T. Belfield, M. D.; A. D. Bevan, M. D.; H. L. Burrell, M. D.; E. H. Bradford, M. D.; C. J. Blake, M. D.; C. S. Bull, M. D.; D. B. Delavan, M. D.; F. S. Dennis, M. D.; Duncan Eve, M. D.; J. H. Etheridge, M. D.; J. A. Fordyce, M. D.; F. H. Gerrish, M. D.; Arpad G. Gerster, M. D.; H. A. Hare, M. D.; W. A. Hardaway, M. D.; J. M. Holloway, M. D.; C. B. Kelsey, M. D.; R. W. Lovett, M. D.; R. Matas, M. D.; H. H. Mudd, M. D.; C. B. Nancrede, M. D.; Roswell Park, M. D.; C. D. Parker, M. D.; J. Parmenter, M. D.; J. Ransohoff, M. D.; M. H. Richardson, M. D.; C. P. Smith, M. D.; E. Souchon, M. D.

In every respect Park's Surgery is up to date. For the student it will prove an excellent text-book. In its pages the practitioner will find almost everything he needs.

Human Anatomy, General and Descriptive, for the use of students. By JOHN CLELAND, M. D., LL. D., D. Sc., F. R. S., Professor of Anatomy in the University of Glasgow, and JOHN YULE MACKAY, M. D., C. M., Professor of Anatomy in University College, Dundee. Illustrated. Octavo, pp. xx-833. The Macmillan Co., London and New York. Price, in cloth, \$6.50.

Once again a systematic treatise upon anatomy has been issued by eminent Scots. The best anatomical treatises issued in our day and generation are the handiwork of Scotch and English anatomists. The present volume is a worthy companion to such treatises as Gray, Macalister and Quain. In no way is the volume under consideration inferior to any of the works mentioned above. The text is above criticism. The language is clear, incisive and to the point. The illustrations, of which more than two hundred and fifty are original, are of great value. Those illustrations which have been reproduced from other anatomical treatises have been selected with care. Some of the most valuable of these are from the treatise of the well-known French anatomist, Testut. The publishers have done their part thoroughly. We predict a favorable reception for the new book.

Davis' Obstetrics. A Treatise on Obstetrics. For Students and Practitioners.

By EDWARD P. DAVIS, A. M., M. D., Professor of Obstetrics and Diseases of Infancy in the Philadelphia Polyclinic, Clinical Professor of Obstetrics in the Jefferson Medical College of Philadelphia. In one very handsome octavo volume of about 600 pages, with 217 engravings and 30 full-page plates in colors and monochrome. Cloth, \$5.00; leather, \$6.00. Lea Brothers & Co., Publishers, Philadelphia and New York, 1896.

Professor Davis' new work affords students and practitioners a concise yet comprehensive guide to the whole art of obstetrics in its most modern development. The author is widely known as a teacher, writer and obstetrician of unsurpassed ability. His thorough acquaintance with foreign literature has enabled him to place at the command of his readers the best material derivable from the vast sources of obstetrical knowledge in the Old World, and his own ripe experience and metropolitan facilities have been equally well utilized in the preparation of the volume at hand. A marked and attractive feature is found in the exceptionally rich series of engravings, among them being a large number of photographic reproductions of obstetrical scenes carefully selected in view of the amount, vividness and permanence of the knowledge which can be so well conveyed in no other way. The book is likewise embellished with a number of most instructive colored plates. In scope it is more comprehensive than ordinary treatises, as it deals with cognate subjects best handled in close connection with their obstetrical precedents, such as the repair of lacerations and injuries, the care of the mother, of the infant, jurisprudence of midwifery, etc. A foremost place may confidently be anticipated for it, both as a text-book and as a work of reference for practical use.

REMINISCENCES,

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter III.

Memories of the College for Medical Practitioners at Saint Louis, Mo.

IN THE year of our Lord 1879-80 it came to pass that a few enthusiastic medical gentlemen conceived the idea that there was an excellent field for a *Polyclinic for Post-Graduates*, there being none in existence in the United States at the time. So, spurred by the desire of being benefactors to the profession and mankind in general and with the aspiration of making their names immortal, they called a meeting for the purpose of converting their longings into reality.

I was not present at this meeting, so I do not know who the select few were, that were honored with an invitation, with the exception, perhaps, of Dr. Thos. F. Rumbold, the well-known nose, ear and throat specialist, editor and owner of the *Medical and Surgical Journal*, and Dr. W. Dickinson, the oculist; Dr. Garland Hurt, Dr. W. B. Outten, Dr. Heine Marks and Colonel Fred T. Ledergerber, *Medical Jurisprudence*, who were among those that favored the gigantic scheme.

Doubtlessly they planned and discussed the matter over and over; naturally they experienced some difficulty in interesting the profession, and the college professors would oppose and condemn the whole affair.

Finally, they gracefully tendered me an invitation to attend the next meeting and assist in the "future great" college. Why I was selected at such a late hour is a mystery to me. However, one of the gentlemen kindly informed me that they knew me to be competent in all respects. "But you speak with a foreign accent, and we are afraid the students would not understand you." (Well, that was left for time to decide.) After mature consideration, I accepted the honors thus thrust upon me, and took an active part.

We had a meeting at the office of the future dean, on Washington avenue, near Thirteenth street. Our faculty was organized as follows: Dr. Thos. F. Rumbold, dean and president of the college; Dr. Edw. Borck, secretary, librarian and museum curator; Fred T. Ledergerber, treasurer (without bond, as there was no money on hand); Drs. W. Hudson Ford, W. Dickinson and G. Hurt, trustees, who waited patiently for any burden to share among them.

There were no lay directors or honorary trustees appointed, as they would be superfluous (for a time, at any rate), and, then, we were all of age and needed no guardians.

The next step was the incorporation. Constitution and by-laws were adopted; a charter was carefully prepared by our legal gentleman (and it was a very excellent instrument). To the best of my knowledge, the above mentioned gentlemen were the charter members.

The charter having been granted, at the next meeting the professors were appointed to their different branches. Dr. Thos. F. Rumbold, professor ear, nose and throat; Dr. W. H. Ford, professor genito-urinary organs; Dr. W. Dickinson, professor of the eye; Hon. Colonel Fred T. Ledergerber, professor medical jurisprudence and history; Dr. G. Hurt, professor of hygiene; Dr. Heine Marks, professor of anatomy and demonstrator; Dr. Edw. Borck, professor surgical diseases of children and surgery in general. As secretary of the college it kept me busy half the night, preparing the announcements and getting them off in time so they might gladden the hearts of the fortunate appointees before breakfast the next a. m. So far, so good. Now came an important step—the selection of a suitable building. A meeting was called and the matter was argued *pro* and *con*.

To the great satisfaction of all, our dean, with his generous spirit and inherent liberality, settled the question. He was willing to sacrifice considerable for the college. He proposed changing his place of residence to a more fashionable neighborhood and transfer the lease of his present residence to the college, at \$100 per month; this building suited our purpose admirably, and as some of the rooms might be rented to members as offices, the expenses might thus be curtailed, etc., etc. His offer was unanimously accepted.

Now came the financial question. "Money's the thing," says the English Jew. How about that? It was agreed that a chair was valued at \$100, and each should occupy one chair. We each made a deposit of \$25, the balance to be paid at intervals, as needed; and you have no idea at what short intervals the rest was required. The dean and one other member made a deposit of \$100; a few adopted the installment plan, and others gave their notes for value received, and everything looked promising.

The dean moved out, the college in.

Every professor was expected to furnish everything necessary for his illustrations and other outfits for lectures and clinics, in addition to the money paid for his chair. Of course, each professor had to establish his own clinic.

Handsomely printed pamphlets (minus typographical or orthographical errors) were circulated through the entire Mississippi Valley, announcing the opening of the first session and the abundance of clinical material ("gratis for the poor." Of this I will tell in another chapter).

All who remember having seen the interior of our neatly arranged little establishment must acknowledge that it answered all requirements for the time being. Everyone connected with the college worked to the best of his ability. Our motto: "As a body work for the college, individually for yourself, collectively for each other."

Before the third session was over our arrangements were about perfected. Our accommodations consisted of a library, dissecting room, a lecture and clinic room, with a goodly supply of material and a fairly good number of attending practitioners.

Our prospects were exceedingly bright, in spite of all opposition. We also selected an additional corps of professors, among whom were Dr. John McIntyre, diseases of women; Dr. Epstein, syphilis; Dr. Ohmann-Dumesnil, and a few others. Dr. W. Byrd, of Quincy, Ill., and old David Prince, of Jacksonville, Ill., gave extra demonstrations of surgical operations upon the cadaver and Dr. Arthur Prince, operations on the eye.

CONCERNING THE FACULTY MEMBERS.

Our dean was a refined, intellectual and learned gentleman. Imagine a well-bred, dignified Scotchman, kind-hearted and possessed of great executive ability, and you have a likeness of our dean. No better man could have been selected to fill the position. He observed everything that transpired, but possessed that rare quality that when questioned about anything his reserved reply was: "You cannot prove it by me." Notwithstanding all these commendable qualifications, there were some who wrongfully accused the dean of being too officious. What a cold, cruel world! (And yet, nature is so true and beautiful a creation.) Dr. W. Dickinson was a tranquil gentleman, a man of letters; he smilingly acquiesced to everybody and everything. (Peace to his ashes.) Dr. Heine Marks was an energetic worker, a good anatomist, and was liked by the students. The other members were all right. Of myself I need not speak.

WHAT THE DOCTORS HAD TO SAY.

This college for practitioners being a new idea, we could expect nothing less than being severely criticised. A tall, well-educated medical gentleman (who had declined an invitation to join) expressed himself as follows: "*Well Borck, do you mean to teach doctors, graduates, anatomy and surgery?* What a ridiculous idea! Do you *suppose* that any one would attend?" And thus our scheme was received. My answer always was simply: "Yes, that is our intention; wait and you will see."

When our first session opened we had nine medical practitioners (graduates) with from five to fifteen years of practical experience; by this time they knew wherein they were lacking, and wished to improve for their own benefit; they were earnest students, with an object in view.

When our session was over, these practitioners went home well satisfied with their work, and some returned a second and third term. A few had strange ideas on the subject; they did not wish to let the people at their homes know why they had come to the city, fearing that it might injure them, so they gave it out that they had been visiting relations; their contemporaries must not be aware of it, for they might also take advantage of the fact and talk detrimentally of the course which they had taken; others said: "My opposition may find out that I have learned something new and he may do the same." And we were forced to hear these and more erroneous ideas. It is safe to say that I told them they were wrong. "Tell your patients for what purpose you have been absent; they will appreciate it and it will do you no harm."

The attendance gradually increased, from session to session. For myself I will say it was a work of pleasure as well as profit.

We had three sessions per year, each lasting thirty days. The practitioners had the privilege of taking the full course or a single ticket for a certain specialty. The object was to give instructions in the different specialties. It therefore happened that one or the other of the professors had one or more students than his colleagues; please remember this point.

[TO BE CONCLUDED IN OUR NEXT ISSUE.]

HISTORICAL SKETCH.

WHO DISCOVERED ANÆSTHESIA? *

By JOSEPH H. HUNT, M. D., of Brooklyn, N. Y.

Chairman Historical Committee, Medical Society County of Kings.

THIS has been a living question for nearly half a century. Could it have been settled in 1849, or in 1852, 1853, or in 1863, which are the dates the different times the subject has been before the U. S. Congress, the country stood ready to grant a substantial recognition to the individual who had conferred this great boon on the human race.

If it could have been answered in 1867, the beautiful monument which was that year erected in Boston's public garden "To Commemorate the Discovery that the Inhaling of Ether Causes Insensibility to Pain," would not have remained without an honored name upon its shaft.

That the battle has been vigorously and stubbornly fought, is shown by the great amount of literature on the subject which helps to crowd our library shelves and the pages of the medical journals of the period between 1846 and 1868, the list of which fills no less than twenty-five columns in the catalogue of the library of the Surgeon-General's Office, which does not embrace all which are known to the writer.

During the month of October just passed there have been numerous celebrations of the semi-centennial of the first application of sulphuric ether for surgical purposes in the Massachusetts General Hospital, which was on the 16th of October, 1846. The operator was Dr. John Collins Warren, an eminent surgeon of that time, and the person who administered the anæsthetic was Dr. T. G. Morton, a dentist of Boston.

If this was really the first time that artificial anæsthesia was produced for surgical purposes, either the name of Warren or Morton, or both, should occupy the blank on the ether monument.

Unfortunately, no sooner had Morton claimed public recognition for the discovery, than several other claimants appeared on the field, each ready to prove that Morton was an imposter, and that Jackson, Wells, *et al*, were the true discoverers.

Sulphuric ether was known to Raymond Lully, who wrote in the thirteenth century. Nitrous oxide gas was discovered by Priestley in 1790. Chloroform by Liebig in 1832.

Anæsthesia has been claimed by numerous writers from the earliest history of medicine, including the ancient Egyptians and the Chinese.

The celebrated Albertus Magnus gives in his "Liber de Mirabilis Mundi" published in 1555, a formula for preparing what he calls aqua ardens. He distills a mixture of red wine, quick lime, common salt, tartar and green figs. You readily perceive that he would get an ethylitic alcohol which, when inhaled in sufficient quantity, would be sufficient to produce anæsthesia.

We learn that there were times when the narcotics, etc., which were administered for temporary purposes only, produced a narcosis lasting some-

* Address delivered before the Brooklyn Medical Society, November 16, 1896.

times for several days and possibly sometimes forever; but as a higher value began to be put on human life, or the work of the experimenter became more under observation of critical rivals, these uncertain methods were gradually abandoned, and we only know of them through obscure and somewhat uncertain sources.

Refrigeration of tissues and the phenomena of hypnotism were also occasionally employed.

An English surgeon, James Moore, published in 1784 a tract entitled "A Method of Preventing or Diminishing Pain in Several Operations of Surgery." He employed clamps and other mechanical methods of producing pressure of the nerve trunks supplying the parts operated upon. Paré is said to have suggested the same method.

Sir Humphrey Davy, at the time Dr. Davy, Superintendent of the Pneumatic Institution of Dr. Thomas Beddoes at Clifton, near Bristol, Eng., made the discovery of the intoxicating effects of nitrous oxide gas, April 9, 1799.

He succeeded in allaying the pain caused by the "cutting" of one of his wisdom teeth by inhalation of this gas; and that it was in a wisdom tooth is shown by the opinion he then and there recorded: "As nitrous oxide in its extensive operation seems capable of destroying physical pain, it may probably be used with advantage in surgical operations in which no great effusion of blood takes place."

Inhalation of nitrous oxide had been used by Dr. Pearson, of Birmingham, for asthma, as early as 1785.

Dr. Warren, of Boston, made use of inhalation of ether in the treatment of the later stages of consumption in 1805.

In 1818 Faraday wrote to the *Journal of Science and the Arts* as follows: "When the vapor of ether mixed with common air is inhaled, it produces effects very similar to those of nitrous oxide. It is necessary to use caution in making experiments of this kind. By the imprudent inspiration of ether a gentleman was thrown into a very lethargic state, which continued with occasional periods of intermission for more than thirty hours, and a great depression of spirits; for many days the pulse was so much lowered that considerable fears were entertained for his life."

In the second edition of Christianson's work on poisons, published in 1839, is related the case of a young man who had been rendered insensible by the vapor of ether; and another of the druggist's boy who had fallen a victim to the stupefying effects of the drug in consequence of having broken a bottle of the liquid.

One year after the first application of ether for producing anæsthesia in a surgical operation in the Massachusetts General Hospital, Dr. John C. Warren, who handled the knife on that occasion, wrote in his little book on "Etherization, with Surgical Remarks," as follows: "A new era has opened to the operating surgeon! His visitations on the most delicate parts are performed, not only without the agonizing screams he has been accustomed to hear, but sometimes with a state of perfect insensibility, and occasionally even with the expression of pleasure on the part of the patient. Who could have imagined that drawing the knife over the delicate skin of the face might produce a sensation of unmixed delight! that the turning and twisting of instruments in the most sensitive bladder might be accompanied by a beautiful dream! that the contorting of ankylosed joints should co-exist

with a celestial vision! If Ambrose Paré and Louis, and Dessault, and Cheselden, and Hunter and Cooper should see what our eyes daily witness, how would they long to come among us and perform their exploits once more! And with what fresh vigor does the living surgeon, who is ready to resign the scalpel, grasp it and wish again to go through his career under the new auspices!"

Prof. Warren was then an aged surgeon about resigning his probe and scalpel to his, since then, no less distinguished son, the late John Mason Warren.

Sir Joseph Lister, in his address as President of the British Association for the Advancement of Science, delivered at Liverpool a few weeks ago, said: "This is the jubilee of anæsthesia in surgery. That priceless blessing came from America. It had indeed been foreshadowed in the first year of this century by Sir Humphrey Davy, who having found a toothache from which he was suffering relieved as he inhaled laughing gas (nitrous oxide), threw out the suggestion that it might, perhaps, be used for preventing pain in surgical operations." * * * "The discovery of anæsthesia inaugurated a new era in surgery. Not only was the pain of operations abolished, but the serious and sometimes mortal shock which they occasioned to the system was averted, while the patient was saved the terrible ordeal of preparing to endure them. At the same time the field of surgery became widely extended, since many procedures in themselves desirable, but before impossible from the protracted agony they would occasion, became matters of routine practice.

"While considering the such signal service to surgery, anæsthetics have thrown light upon biology generally. It has been found that they exert their soporific influence not only upon vertebrata, but upon animals so remote in structure from man as bees and other insects. Even the functions of vegetables are suspended by their agency. They thus afford strong confirmation of the great generalization that living matter is of the same essential nature wherever it is met with on this planet, whether in the animal or vegetable kingdom. Anæsthetics have, also, in ways to which I need not here refer, powerfully promoted the progress of physiology and pathology."

In the beautiful park known as the Public Garden, of Boston, Mass., there was erected in 1867 a monument to the unknown. A celebrated teacher of medicine is accustomed to annually tell his class in the medical college with which he is connected, that in Boston they have solved the uncertainty of the personality of the discoverer of anæsthesia by erecting a monument to "either" (ether).

It bears on its four faces the following inscriptions:

"To commemorate the discovery that the inhaling of ether causes insensibility to pain; first proven to the world at the Massachusetts General Hospital in Boston, October, A. D., MDCCCXLVI."

"Neither shall there be any more pain."—REVELATIONS.

"This also cometh forth from the Lord of Hosts which is wonderful in counsel and excellent in working."—ISAIAH.

"In gratitude for the relief of human suffering by the inhaling of ether, a citizen of Boston has erected this monument, A. D., MDCCCLXVII. The gift of Thomas Lee."

Upon the summit of the exceedingly ornate monument is the statue of

a physician holding a patient reclining in his arms, while he is in the act of administering the anæsthetic.

There is no doubt but that the exhilarating and intoxicating, as well as the antispasmodic, effects of inhalations of sulphuric ether were well known in the early part of the present century.

Dr. Pearson, of Birmingham, employed it in the treatment of spasmodic asthma in 1785, and Dr. John Collins Warren, of Boston, whose letter on the subject of anæsthesia has just been quoted from, made use of inhalations of ether in the treatment of the later stages of consumption in 1805.

College students pursuing their chemical studies learned the exhilarating effects of nitrous oxide (laughing gas) and sulphuric ether, and in boyish spirit experimented with the mysterious agents, and carried the knowledge thus gained to their homes and instructed their young companions; and to get some one to inhale one of the intoxicating agents, and observe his behavior, became one of the pastimes of gatherings of young people. Thus we find that in Northern Georgia the young people held what they called "ether frolics," and one who was an active participator in those affairs, says "that there was hardly ever a gathering of young people that did not wind up with an ether frolic. Old-fashioned 'quiltings' were very common at that time, and in the evening the boys and young men would go to these for the purpose of a dance or an ether frolic."

The late Dr. J. Marion Sims, of New York, in his "Discovery of Anæsthesia," tells of such an occasion. "The girls and boys all finished the evening by inhaling ether. Some would laugh, some cry, some fight, and some dance, just as when nitrous oxide is inhaled." They were looking for new subjects when they perceived a colored lad peeping through the open door. Notwithstanding his resistance and violent struggles, the young men forcibly administered the ether to the young negro.

After a long struggle he became quiet and unresisting. The young men were greatly surprised that he did not get up immediately and say or do some foolish thing for them to laugh at. He lay quietly, and with stertorous breathing. They tried to rouse him, but could not. They then became greatly alarmed and sent one of their number for a doctor who lived five miles away. The messenger found the doctor at home and they lost no time in returning to the scene. They found the young men who had administered the ether contemplating making their escape from the country, thinking that they had killed the boy; but the doctor's arrival reassured them, and fortunately his efforts were crowned with success—he was roused to consciousness after having been under the influence of the ether for over an hour. The doctor read them a severe reprimand, warning them of the danger of such frolics and cautioned them against a repetition of them. This act broke up the ether frolics of that neighborhood. This was in 1839.

Dr. Sims says that "this is unquestionably the first case in which sulphuric ether was ever given to the extent of producing complete anæsthesia."

In 1842, the romping boy who had administered the ether to the young negro a few years before became a medical student in the office of Dr. Crawford W. Long, in the village of Jefferson, in Jackson county, Georgia. Dr. Long was not so much older than his students but that he could be on familiar terms with them, and entered into their discussions and experiments more as a companion than a preceptor. All of them, including the

doctor, were more or less acquainted with the ether frolics of the neighborhood, and young Wilhite's escapade with the colored boy was freely discussed; and all experimented with the ether on each other, and noticed that on recovering from the ether intoxication they would sometimes find their persons bruised by having come in contact with the furniture or otherwise, and were not conscious of pain at the time. These facts suggested in the mind of Dr. Long the idea of using ether to prevent the pain of surgical operations. The first favorable opportunity that offered was on March 30, 1842, when he removed a small tumor from the neck of Mr. James M. Venable. The ether was administered on a folded towel, and as soon as he



DR. CRAWFORD W. LONG.

came under the influence of the drug the cyst was removed without any evidence of suffering on the part of the patient, who asserted that he did not experience the slightest degree of pain, and was incredulous when assured that the operation was completed.

Dr. Long was at the time a "country doctor," a general practitioner, who like "Tan MacLaren's" Dr. MacLure, "was chest-doctor, and doctor for every other organ as well; he was accoucheur and surgeon; he was oculist and aurist and dentist, besides being chemist and druggist." A man "who had to do everything as best he could and as quickly." He lived and practiced in and about a country village, then more than a hundred

miles from a railroad, with no medical societies where he could meet his professional confreres and inform them what he had done and gain wisdom and ambitious enthusiasm from their criticisms or commendations. He did not feel the importance of sending his valuable experiences to a medical journal that they might become matters of record. In fact, I do not believe that he was aware that he had done anything of exceeding great importance or that no one else had done the same thing. So he worked unknown and "wasted his sweetness on the desert air."

It was not until December, 1849, that Dr. Long published in the *Southern Medical and Surgical Journal* an account of his first experience, which happened over twenty months before Gardner Q. Colton administered nitrous oxide to Horace Wells in Hartford, Conn., and more than three and a half years before W. T. G. Morton administered sulphuric ether in the Massachusetts General Hospital for Dr. John Collins Warren to perform a long and painful operation upon a telangiectasis of the neck. Dr. Long continued to do the little surgical work of his Georgia village without permitting his patients to feel the pangs inflicted by the keen-edged knife; and while the wonder became the village talk of his neighbors, their world was small. Dr. Long had no hospital or other opportunity in that quiet country life to perform an operation which he would regard as being of a magnitude worthy of reporting.

It was not until Morton and Dr. Jackson had presented their petitions to the National Congress, asking for a reward and remuneration for their services that the Georgia physician put in his claim for recognition.

One of the claimants for the honor and its rewards (Dr. Jackson) visited Dr. Long at Athens, Georgia, to which place he had removed after his early experience in Jefferson, and said to him: "You have the advantage of priority of date and in the first use of ether as an anæsthetic, but we have the honor of priority of publication." We shall see later whether they could even claim that.

Had Dr. Long resided in a large city where his experience could have been repeated and verified in some hospital, with capital operations, such as do not come more than once in a lifetime in the experience of a country surgeon, the world would have been the gainer by fully four years in the great benefits derived from his discovery, and no one would have been able to dispute the honor with him. Like Paré and Jenner, he might have become known as one of the world's greatest benefactors. As it is, his experience is but an interesting incident in the history.

"Of all sad words of tongue or pen,
The saddest are, it might have been."

[TO BE CONTINUED.]

Insomnia in the Insane.—In an article entitled "Practical Psychiatry," Dr. E. G. Carpenter, of Cleveland, consulting neurologist to the City Hospital, states that the medical treatment of the insane rests upon this tripod of essentials—rest, sleep, and nourishment. In the treatment of insomnia the mildest methods for encouraging sleep should be employed. Should we be forced to the use of drugs, the least injurious should be tried first, as lupulin, bromide of sodium and trional.—*Cleveland Journal of Medicine*, November, 1896.

MEDICAL PROGRESS.

A New Method for the Radical Cure of Inguinal Hernia Without Buried Sutures.—Dr. Simon Duplay, Professor of Clinical Surgery at the Medical Faculty of Paris, Surgeon to the Paris hospitals, and Dr. Maurice Cazin, Chef de Clinique Chirurgicale at the Medical Faculty of Paris, in the *Medical Week*, say: “In order to completely do away with buried sutures we must abandon the usual method of operation, which comprises: (1) ligation of the hernial sac by one of the ordinary means; (2) suture or, more correctly, approximation with the aid of buried sutures, of the pillars; (3) ligation of the vessels and deep sutures of the soft parts, which are employed by certain surgeons in performing the radical cure of hernia. It is needless to state that we do not refer to ligatures necessitated by resection of a portion of the herniated omentum, for silk sutures left in the peritoneal cavity do not give rise to the remote ill-effects sometimes determined by sutures buried in the abdominal wall.

“Ligation of the arterioles may be easily avoided by twisting, which never fails to completely arrest the hemorrhage.

“With regard to the suture of the soft parts, more particularly approximation of the pillars by means of buried sutures, we are of opinion that, in the majority of cases, the object aimed at may be attained by the use of silver-wire sutures, properly placed and comprising at each margin of the wound as large a quantity as possible of the soft parts. The coaptation of the tissues under such conditions is excellent, and, when the sutures are removed, the cicatrix of the inguinal ring is dense and firm, as we have found in all our patients. It is only in the comparatively small number of cases in which a good result can be obtained only by Bassini's method that it is necessary to employ a deep row of buried sutures.

“In the majority of cases, therefore, a perfectly firm cicatrix is obtained with two or three deep silver-wire sutures, including the pillars and four or five others, comprising all the soft parts which can be gathered up in front of the inguinal ring, just as well as with deep buried sutures.

“The novelty, however, of the method of operation to which we wish to call attention consists principally in the manner of closing the sac. We have in fact succeeded in doing away with placing a silk ligation on the hernial sac, employing instead the following method, from which we have invariably, in all patients operated upon, obtained most satisfactory results:

“The cavity of the sac having been opened and examined with the finger, the existing adhesions are destroyed, and a portion of the herniated omentum is resected if necessary, after which the sac is completely dissected out with the greatest care, the peritoneal layer alone being taken. This dissection is pushed until parts of the peritoneum normally situated 2 or 3 centimetres above the inguinal ring can be pulled out. An assistant then takes hold of the sac at its base, and the operator ties all of this sac into a knot (Fig. 1), which is pushed up as far as possible before it is drawn tight. To prevent this knot from becoming untied, if the sac is sufficiently long, another, and even a third, similar knot is tied, one after the other, or a double knot is made, though this is less satisfactory from the point of view of firmness; then the entire remainder of the sac is split in two, and the strips thus obtained are tied together once or twice (Fig. 2). Lastly, in order to insure absolute firmness, a hole may be made in one of these strips and the other passed through it (Fig. 3), so as to prevent all possi-

bility of the knot slipping; this manœuvre, moreover, may be repeated two or three times (Fig. 4), if the strips are sufficiently long. When the sac is short, it is frequently impossible to tie more than one knot with the entire sac; in this case the knot is secured, as stated, by splitting the remainder of the sac in two strips, which are then tied together once or twice (Figs. 2 and 3).

All these manœuvres, which are executed in less time than it takes to describe them, are carried out not with the fingers, which frequently would not be possible, but with the aid of forceps, when they are executed with



FIG. 1.



FIG. 3.

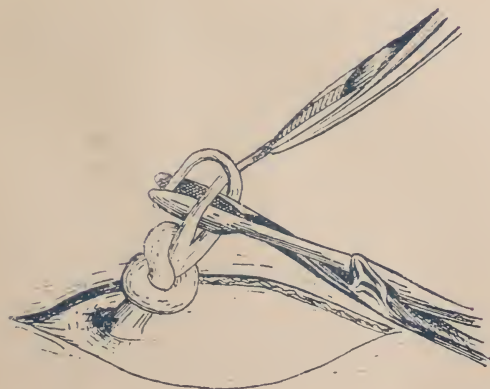


FIG. 2.

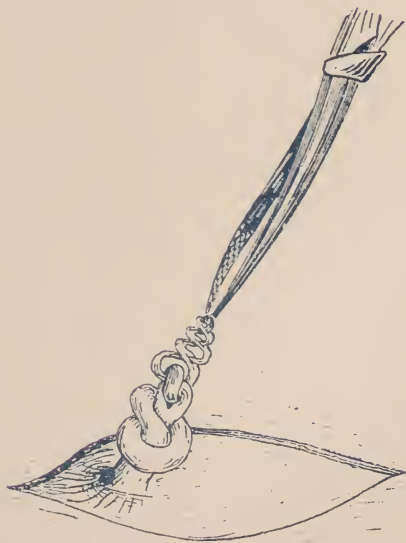


FIG. 4.

ease, as will be seen from the accompanying drawings, for which we are indebted to Mr. Ombredanne, our house-surgeon.

The last knot having been tied, the sack is released, when it disappears at once in the abdominal cavity, exactly as when the sac has been resected in the usual operation. In all the patients operated upon we found that the highest point of the knot farthest away was invariably situated at least 3 or 4 centimetres above the internal inguinal ring.

“It then only remains to finish the operation in the usual way, except that silver-wire sutures are employed, as stated above.

“In cases of old-standing herniæ, the sac may be so thick as to preclude its being tied in its entirety. In two cases of this kind we were obliged to give this up and split the entire sac in two at once, tying the two ends together several times in the manner indicated in Figs. 2 and 3; in one case, we even split the sac into four equal parts, and tied them together two and two, the results thus obtained being very good.

“The radical cure of herniæ without buried sutures has already been attempted by Dr. Poulet, who has devised for this purpose a method of tendinous autoplasty (*The Medical Week*, 1895, page 553). Our procedure, which differs entirely from that of Dr. Poulet, is much simpler, and we are of opinion that, in the majority of cases, it should be preferred to the usual method of ligature of the sac, because it does away entirely with the possibility of ill-effects ultimately resulting from the presence of buried sutures in the parietal tissues.”—*The Medical Week*.

The Bubonic Plague.—James Cantlie, of Charing Cross Hospital, London (*The Medical Press and Circular*, January 6, 1897), gives the following conclusions drawn from a study of the spread of the plague.

VARIETIES.—1. The varieties of plague known under the names (*a*) fulminant, (*b*) typical, and (*c*) pestis minor are allied.

2. The cause of fulminant and typical plague is a diplobacterium in the blood and tissues. The cause of pestis minor *may be* an allied diplobacterium, but with a lesser toxic power.

3. An appropriate name for the (fulminant and) typical plague is “Malignant polyadenitis.”

4. An appropriate name for the mild variety, pestis minor, is “Benign polyadenitis.”

INFECTION AND CONTAGION.—1. Plague is infectious, chiefly, by the dust arising during the cleansing of dwelling houses which plague patients have occupied.

2. Plague is contagious by prolonged and intimate contact with the plague-stricken, as in the case of a nurse carrying a child ill of the disease.

DISTRIBUTION.—1. Plague is met with in a definite area of Asia, which may be termed the “plague belt.”

2. The home of plague at the present day is Mesopotamia and the countries adjacent.

3. From Mesopotamia as a focus plague may spread northwards to the Caspian Sea; westward to the Red Sea; southwards as far as Bombay; and eastwards as far as (Formosa) the China Sea.

4. During the present century plague has shown a western retrocession and an eastern accession of virulence.

THE BACILLUS.—1. Typical plague (malignant polyadenitis) is associated with pestis minor (benign polyadenitis).

2. A bacillus of somewhat similar appearance microscopically, is reputed to be found in both. (This is under discussion now, December 29, 1896.)

3. The bacilli differ in their toxic powers.

4. A benign polyadenitis may run its course without being preceded or followed by the malignant variety.

5. Malignant polyadenitis may run its course without being preceded or followed by the benign variety.

6. The bacillus of the benign variety may attain malignancy by passing through some intermediate host, possibly, but not probably, the rat.

PUBLISHER'S DESK.

Hydrozone in Gastric and Intestinal Disorders.—A period of nearly twelve years has elapsed since I first began the clinical use of hydrogen dioxide, generally referred to at that time as the peroxide of hydrogen. In 1887 I published a paper giving a detailed account of several cases in which it had been employed by inhalation, but even then I was thirty years behind the report of Dr. (now Sir) Benjamin Ward Richardson, of London, who had made a thorough investigation of its antiseptic, detergent, and healing properties. Notwithstanding the fact that this preparation had been known to the medical profession for that length of time it had achieved little or no reputation. This, however, may be explained by the fact that the discovery preceded the dawn of bacteriology. Indeed, I was one of the early contributors to medical literature relating to the clinical value of this product, and since that time I have published a number of articles, embracing practically every application, both medical and surgical, to which hydrogen dioxide is adapted.

In the present communication it is my object to direct the attention of the profession to its special value in the treatment of gastric and intestinal disorders. In gastritis, for example, there is no antiseptic which can be given with so much benefit as this remedy, because its effect is immediate, and even in considerable doses it is absolutely harmless. The same is true in regard to its employment in typhoid fever, cholera infantum, and Asiatic cholera. In the latter disease its efficacy has been thoroughly demonstrated by a number of well-known physicians, and its applicability in cholera infantum is well known to those physicians who have given careful attention to the most modern methods in the treatment of this class of cases.

The following brief notes will be sufficient to indicate the availability of this remedy in the treatment of the disorders already mentioned, although, in view of the fact that hydrozone is a more concentrated product, and withal a permanent solution, this latter remedy should have the preference. It contains at least double the volume of nascent oxygen which has heretofore been the standard for the medicinal peroxide of hydrogen.

In gastritis, either acute, subacute, or chronic, we have to deal with an unhealthy condition of the lining membrane of the stomach. The inflammation is attended with an increased output of mucus, which seriously interferes with the normal functions of the peptic glands. By the introduction of a small quantity of hydrozone, in the strength of one part to thirty-two parts of boiled or sterilized water, this objectionable mucus is at once destroyed by the action of the oxygen which is released, and the contents of the stomach remaining are promptly discharged into the small intestine. A patient suffering from gastritis should take at least half an hour before meals from two to four ounces of diluted hydrozone (one to thirty-two) and lie on the right side so as to facilitate the action of the stomach in discharging its contents.* The antiseptic properties of hydrozone thus used are sufficient to destroy the micro-organisms and leave the stomach in a healthy condition for the absorption of nutritive pabulum. All forms of fermentation are promptly subdued by the active oxidation resulting from the liberation of nascent oxygen. The patient is then in a condition to take suitable food, which should be nutritious and easily digested, liquids being preferred until the active symptoms have subsided. Later, small portions of solid food can be ingested, but all food stuffs of a starchy character must be thoroughly masticated, in order to secure the action of the salivary secretion upon the starch granules, breaking them up, and lessening the tendency to fermentation in the stomach. After taking a meal, a patient with gastritis should follow it with medicinal doses of glycozone, which contain, in addition to the nascent oxygen contained in hydrozone, a percentage of glycerine which favors osmosis and assists in re-establishing the functional activity of both the peptic and mucous glands of the organ.

In the treatment of cholera infantum, typhoid fever and Asiatic cholera, the same general plan should be adopted in dealing with the stomach, always bearing in mind the necessity of having the patient remain in the recumbent position and on the right side for at least half an hour after the ingestion of the solution. In addition, however, to the preliminary treatment of the stomach, the same solution (one to thirty-two) is used as an injection into the lower bowel, care being exercised to insure its introduction as high up as possible. This can be managed by having the patient lie on the left side, with the hips well elevated, and the employment of a long flexible rectal tube. In this manner we secure and maintain an antiseptic condition in both the stomach and large intestine, the importance of which will be understood when we consider the large number of micro-organisms which grow under these favorable conditions with such remarkable rapidity.

When deemed advisable, the solution introduced into the lower bowel may be combined with large quantities of either hot or cold water, which enables us to obtain the benefits of irrigation in addition to the antiseptic effects. These irrigations may be employed as fre-

*In chronic cases with a large output of gastric mucus, and particularly in gastric ulcer, concentrated solutions are not well borne at first, owing to the formation of oxygen gas, but this difficulty disappears with the continued use of the remedy, and no treatment of gastric ulcer can be regarded as complete without the local employment of hydrozone.

quently as deemed advisable by the medical attendant, but they will usually prove satisfactory if administered at intervals of four hours.

Although brief, it is believed this communication will prove serviceable to a large number of practitioners who have hitherto found serious difficulties in counteracting the mephitic influences of bacteria in this class of disorders, and the clinical virtues of the remedy being now so fully recognized, no one will hesitate to adopt the methods suggested, which may be conveniently carried out in addition to the usual routine treatment.—*John Aulde, M. D., in New York Medical Journal.*

Campho-Phenique Powder in Leucorrhœa.—For over four years I have been constantly using your Campho-Phenique as a dressing in all my surgical cases, and not in one instance have I been disappointed. I am delighted, not only with its antiseptic action, but also with the local anesthetic action it produces. About a month ago one of your representatives left a sample of your Campho-Phenique Powder with me and I have used same in treating four cases of vaginal leucorrhœa, all of which were of months' duration. I applied the powder to the tampons (cotton) after anointing same with vaseline. After each application the discharge lessened remarkably, beside the pain and inflammation subduing almost entirely after first treatment. In two cases I made four applications; in the other two cases six applications, when all the discharge disappeared. I was so surprised and pleased myself with the action of your powder, that I felt that I would be doing you an injustice not to write and inform you of my favorable results. I don't know if I am the first to use your powder on tampons, and if future results as favorable follow, I shall surely use it exclusively in treating leucorrhœal troubles. If you will forward me another ounce of your powder I will further test its efficiency in gynecology and report. Yours very truly,

E. C. SCHOLER, M.D., Ph.D.

1 and 3 Clark street, Chicago, Ill., November 5, 1896.

Neurosine vs. Morphine. Positively No Morphine in Neurosine.—Neurosine is the most powerful neurotic attainable, quieting the nerves and producing natural sleep. Physicians should never prescribe or recommend any product which the laity could obtain from the druggists to produce sleep that contains morphine. There is hardly a day but what fatal results occur (to those using stimulants to excess and other causes) who resort to neurotics to steady their nerves and produce sleep. It is hard for one to believe that manufacturing chemists would be so unprincipled as to compound morphine without indicating same in formula. The Dios Chemical Co. of St. Louis, manufacturers of Neurosine, publishes the formula complete, which is composed of the following well-known and tried drugs: Chemically Pure Bromides of Potassium, Sodium, Ammonium, Zinc, Extracts of Henbane, Belladonna, Lupuli and Cascara Sagrada with Aromatic Elixirs.

Ferratin.—Marfori (*Archiv. Ital. de Biol.*, Tome XXIII., Fasc. I-II) publishes the results of some recent experiments upon the absorption of ferratin and its physiological action. He states that the quantity of ferratin that can be absorbed depends largely upon the condition of the mucous membrane of the gastro-intestinal tract. Sulphuretted hydrogen, which accompanies putrefactive processes in the intestine, slowly decomposes ferratin (it immediately precipitates ordinary iron compounds.—Ed.), and so reduces the amount capable of being absorbed. The large amount (13.7 to 41.68 per cent.) that occurs after administration of saline purgatives Marfori ascribes in part to the aseptic condition of the bowel, and in part to the fact that the saline purgatives cause a desquamation of the upper layers of the intestinal epithelium, and therefore expose a thinner layer of young cells through which absorption more readily takes place.

When the gastro-intestinal canal is in its normal condition the absorption of ferratin is much less, according to Schmiedeberg, but since the latter's experiments render it impossible to distinguish between the iron of the ferratin and the iron introduced in the food, Marfori proceeded as follows: He administered to the animal a saline purgative, and fed it solely on milk; the lower part of the intestine was also cleared of saline enemata. About a week later ferratin was given in repeated doses. The amount absorbed varied between 11 and 30 per cent. of the amount administered.

With reference to the question whether ill-effects might not arise from long-continued administration of the drug, Marfori found that it was impossible to poison animals by injecting large doses into the blood, nevertheless a man would need to take about two and a quarter pounds of ferratin in the course of a month to produce a similar result, assuming as a basis for calculation experiments on dogs. Since he would actually, however, only receive about one-twentieth of that amount, there is no danger in continued administration of the drug, a statement confirmed by clinical experiments.—*Univ. Med. Magazine*, Nov., 1895.

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ST. LOUIS, MO., FEBRUARY, 1897.

No. 2.

ORIGINAL ARTICLES.

A RESUMED NOTE UPON FIVE HUNDRED CASES OF LARYNGEAL NEOPLASMS.*

By PROF. F. MASSEI, of Naples, Italy.

IN the year 1884 I published a statistical account of 200 cases of tumors of the larynx, which I met in my practice, and since then the number has increased, till it gives, at present, an amount of 500 observations. It might prove tiresome to give a second statistical work. I have thought it of not indifferent utility, both for specialists and practitioners, to communicate, shortly, the considerations suggested me by a long experience. With this object in view I can consider only the practical effects, which can be deduced by prevalence, frequency, symptoms, and therapeutic indications concerning growths in the larynx.

Not long ago, an opinion was emitted that growths in the larynx were not now so common as before, and notwithstanding my 500 cases I cannot but confirm this opinion.

The credit acquired by laryngology and laryngologists invites, at present, patients to treat, in whom we find every light disease; hence, a first reason for which predisposing causes are lessened.

In the second place, we cannot deny that in a moment of high enthusiasm, all patients suffering with the throat for a long time, applied

*Written expressly for the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

to our consultations, and a large demolition of tumors, formed in the space of many years, was accomplished in a short period. Finally, I have to call attention to the fact that, for special conditions, I see patients, not only of the town in which I live, but even of the neighboring cities; the great number of cases which I propose to discuss are, then, not in contradiction with the observation already cited.

According to their nature and frequency, the 500 cases may be so distinguished:

Papillomata	183
Fibromata	156
Epitheliomata	67
Cystic tumors	27
Sarcomata	10
Myxomata	6
Encephaloid	5
Amyloid tumors	4
Adenomata	2
Gummata	2
Nature not determined in	38 cases.
	500

I continue to call, in general, neoplasms true tumors and growths. Clinically, the difference between benign and malignant tumors has not been shaken by all modern progress in histology and bacteriology; but the exact recognition of the nature is an element of diagnosis which does not justify the separation adopted by some authors.

The reader, however, can be sure that this classification of my 500 cases is founded:

- (1) Either on the base of an histological examination (which I took care to confide to competent men);
- (2) Either on the typical appearance of the tumor (when possible);
- (3) Either on the clinical course and the issue, when doubts persisted in spite of every diagnostic supply.

I can say, then, that this classification, if not mathematically exact, has, in its favor, all the warrants it was possible to me to reach.

PAPILLOMATA.

The first place occupied by papillomata (183 cases) confirms exactly what Mackenzie announced since the publication of his excellent work on "Growths in the Larynx" as regards their frequency.

We can separate cases of diffused papillomata, or papillomata which recur with great readiness, from those who remain limited and are not apt to recur, staying in place like a simple *caput-mortuum*.

The well known phase of recurrence, so common in papillomata, implies danger which must be present to the mind of the physician; because not seldom the urgent necessity of a tracheotomy arises in a sudden manner. But, happily, at the end of one or two years this *progressive stage* seems to stop, and endeavors to remove the growth are now finally successful.

I have seen, however, a patient in whom recurrence took place twice: after six years, once; and, three years, the second time. Opposite to this, I have soon to remember the *regressive phase* which can end in a complete

disappearance of the tumors, not rarely spontaneously, as observed in children.

Garel has so well insisted upon this fact, and I have, myself, related a case in which a year after tracheotomy in a boy (performed in a hurry), I was able to remove the tracheal cannula.

The interest of these few considerations is great in regard to the treatment. I shall limit myself to say that against laryngeal papillomata we must consider at first if, for the age of the patient and the degree of the laryngeal narrowing, it is possible to reach the tumor by laryngoscopic way without danger.

Often I prefer currettes to common forceps, when the growth is more infiltrated than prominent, and from local application of ichthyol (one to ten of distilled water) I had, as for what concerns recurrence, better results than from caustics.

But if a laryngoscopic examination is not possible, and it is necessary to correct the difficulty of breathing, I am convinced (and insist now, more than before) that simple tracheotomy may be sufficient.

If, after a time (one or two years) the tumor persists, there is, then, no contra-indication for thyrotomy; but the practice of beginning by this (as surgeons, and not specialists do) is, according to my views, not only wrong, but also erroneous. I can mention a very demonstrative case.

Amongst my 183 cases there is a girl 11½ years old, who was last September operated on (thyrotomy) on account of a severe dyspnoea for laryngeal papillomata. Breath restored; voice only improved after operation, and a month after again aphonia. For this, the little patient applied to me in December, and I could easily see, on the edge of the left vocal cord and in the sub-glottic space, papillary growths, which I removed by laryngoscopic way with complete return of the voice.

FIBROMATA.

The second place, after papillomata, is taken by fibromata (which are at the number of 156 among 500 cases). I hope to explain directly the reason of this frequency, saying that, really, it is not a question of true fibromata, but of a variety of "*cystic fibromata*."

In the greatest number of cases which, in fact, came under my observation, conjunctive tissue was lazy, reticulated, full of spaces which contained a semi-liquid substance: at the surface layers of plated-cylindric epithelium which formulated a lucid layer; hence, the apparent formation of *lacunæ* resembles such growths strictly to so-called *molluscum fibromosum*. We can, then, with right, announce that if there are true fibromata, *i. e.*, tumors which arise from sub-mucous tissues or perichondrium, the fountain from which more frequently they arise, is more superficial; the pathological signification more benign, though the rapid augmentation of the interstitial spaces, or an hemorrhage may give rise to alarming symptoms on account of a quick enlargement of the growth.

But, in general, such neoplasms which take, willingly, a bi-lobulated or tri-lobulated appearance, of a red contour, often very strong, with a well-marked pedicle, do not reach a considerable volume; very seldom they recur, when extirpated (the recurrence has been seen by me in few instances). Only once, I met with a so large fibromata of the petiole of

the epiglottis that I was obliged to do tracheotomy in order to prevent death by asphyxia.

EPITHELIOMATA.

Sixty-seven cases of laryngeal epitheliomata amongst 500 of laryngeal neoplasms is a striking number which demonstrates how frequent it is in the larynx, and in a primary form, cancroïd.

I have not to insist upon difficulty of diagnosis, sometimes; upon the great value of fixity of the vocal cord (as Semon first pointed out); upon necessity of a therapeutic trial (antisyphilitic treatment) in doubtful cases; and, the negative results of a microscopic examination of small pieces removed in many cases.

I like, on the contrary, to call attention upon the services which illuminating the hypoglottic tract by transparency, can render us, in some instances; and, as regards the argument, I cannot omit that Desvernine, in a remarkable paper, published in the *Revista de Ciencias Medicas*, Habana, in December, 1893, has given very useful conclusions upon the results of such an examination, and pointed out that dark spaces in the sub-glottic region meant infiltration of the tissues, in a more large measure than was to be thought after a simple laryngoscopic examination, and as is the case for malignant tumors.

It seems that not a good fortune smiles upon Röntgen's rays; but we cannot renounce at all to further investigations. The interest of an exact diagnosis is great as regards treatment. Therapeutically I cannot draw any useful teaching from these sixty-seven cases (as well from those of sarcomata and encephaloid) as regards a radical treatment, because, for the concurrence of many circumstances I never was able to decide patients for laryngectomy. Only a certain number of times (nineteen) I was allowed to perform tracheotomy in order to save life in imminent danger, and from this I have seen confirmed what was already known, *i. e.*, that tracheotomy, when performed in time, may prolong the course of the cancroïd in the larynx, which shows a natural tendency for a slow proceeding (four years or more).

But I am also convinced that semi-laryngectomies reach better results than total extirpation, although Prof. Nevaro (in Bologna) has published several striking cases in which a late operation was followed by satisfactory success.

The interesting question which I presented for discussion may be referred as follows:

Considering that statistic statements demonstrate how more successful are partial than total laryngectomies;

Considering that, for doing the first instead of the latter, a limitation of the disease is necessary.

In order to lessen the rigor of malignant laryngeal neoplasms, it is necessary to make an early diagnosis.

Early diagnosis, however, is not always an easy or possible matter, as microscopical examination is not always demonstrative.

Hence, the necessity of relying, not seldom, upon a clinical diagnosis made by an expert laryngoscopist, without forgetting to repeat microscopical examination.

But the question of the treatment does not end with the diagnosis; we

must explain, without reticence, to such patients, or their families, the dangers of the disease and those (recent and late) of the operation. In making this, the physician wants not only the surety of his own observation, but the whole confidence of the patient, who, in the first stages of the disease, often does not complain of more than a simple hoarseness.

I stop here, confessing to have in few words expressed the truth, in regard a matter so difficult, a disease so terrible.

CYSTIC TUMORS.

Opinions about frequency of cystic tumors are not united; but it is evident that unlike the most common forms, they are not prevalent.

My twenty-seven cases may, however, be tabulated in the following manner: Thirteen amongst the first series of 200 cases; fourteen amongst the second.

I cannot omit to recollect, however, that since 1884, Prof. Cervesato, of Padova, who had expressed the opinion that cystic tumors were not rare, collected eighty-five cases, in which are enclosed his own interesting observations.

The prevalent seat is the vocal cords or the epiglottis; the appearance characteristic enough; it is difficult to mistake them (they resemble mucous polypi).

Their origin from the vocal cords confirms the idea that they may be considered as true mucous cystic tumors in consequence of retention of the secretion of mucous glands by obliteration of their ducts. But the contents may also be serum, blood, fibrin, or transformation of secretive products.

The easy recurrence emphasizes the necessity of a cauterization after cutting them and an observation for some time. They can reach the volume of a cherry.

SARCOMATA AND ENCEPHALOID.

Both complete the class of malignant tumors observed in the larynx, and I have only to call attention of the reader to what I already said in regard to epitheliomata.

Sarcomata and encephaloid are more rare than the last. I have seen only ten cases of sarcomata and five of encephaloid (the same published in my first statistics of 1884).

If the diagnosis is not always an easy one (as the apparent feature is not characteristic) and a microscopical examination often required, from a clinical point of view I have to reiterate the frequency with which sarcomata recur, the early ulceration and the rapid course of encephaloid.

As for the treatment, I cannot but repeat that an early diagnosis of the nature of the growth affords the only chance of success for an early surgical intervention.

I met always with advanced cases. I can then say nothing in regard to the value of an early removal by natural ways in incipient cases (as the few known in the literature concern sarcomata) or a simple thyrotomy; but I cannot contradict that in case of sarcomata an attempt before laryngotomy in the first stages may be quite justified.

MYXOMATA.

Even myxomata are not common in the larynx. I have met with them only in six instances, and isolated cases are here and there reported.

It seems that the *papillary* variety is the more frequent, and in general the structure is the fibro-cellular, with a different quantity of serous liquid or gelatinous substance. A fibrous covering with epithelial layers has also been frequently seen. They resemble (as already said) cystic fibromata, but the color is not red, but pale. They do not reach a considerable volume and have not a tendency to recur.

Often it is the microscopical examination which teaches the true nature, and it is probable that such a precaution for every extirpated growth may confirm, in a less or more recent time, if they are less rare than thought at present.

AMYLOID TUMORS

Are simple curiosities. In my 500 cases they appear only four times.

Amyloid tumors may be multiple, little in size, round in form, or large; but they can be seen also isolated on the vocal cords.

Twice the diagnosis was only clinically stated: twice it was a microscopic examination which instructed me.

In my first two cases the windpipe was also the seat of little growths, and severe dyspnoea was present. Once tracheotomy was performed; in the second no operation was done and the patient died.

In the third and fourth instance the growths were small, round, similar to cystic fibromata, placed over the vocal cords. Extirpated, they did not recur. One of my assistants, Dr. G. Martuscelli, who undertook a microscopical examination, informed me that they consisted, for the greatest part, of a matter which colored itself well, only under the special iodine reaction (it was then, no doubt, amyloid substance) from conjunctive tissue and epithelial layers. He is to continue his studies, but I can conclude that amyloid tumors may be separated into two classes—those in which, according to the opinion expressed by Ziegler, the presence of amyloid substance, in form of multiple growths, not only in the larynx, but also at the base of the tongue and elsewhere, may be attributed to circulatory troubles; those in which the accidental presence of amyloid substance may have a more local signification.

But it is also highly probable that if careful investigations may be done in this sense over all cases of laryngeal growths, the presence of amyloid substance can be detected oftener.

ADENOMATA—GUMMATA.

Adenomata and gummata, both together, are rare as amyloid tumors. I have to mention two cases for each variety.

As for *adenomata*, it must be observed that they deserve this name only when hypertrophied racemous glands are exclusively found. Hence, the facility of mistaking them, microscopically, with adenoid cancer.

Adenomata can reach a considerable size; they have been seen over the vocal cords, the epiglottis, the exterior surface of arytenoid cartilages. They have no characteristic appearance, but may resemble a tonsil and recur (as in one of my two cases).

Of the two cases of *gummata* with which I met, once it was in the hypoglottic tract and required tracheotomy; the cannula was soon removed, but a posterior adhesion of the vocal cords claimed, some time after, a new operation, and the patient, an old woman, is still living with the tracheal cannula.

As for the second case, I cannot give further information; but I remember that a specific treatment succeeded in improving a large growth which issued from one of the laryngeal ventricles.

GENERAL CONSIDERATIONS.

It is not possible for me to enregister exact news regarding issue and therapeutics of these 500 cases:

(1) Because several patients (suffering only from hoarseness) refused treatment, fearing an operation;

(2) Others applied to other physicians, hoping in a mistake from my part, or confided to the hazard their voice or their life;

(3) And some others, finally, have not informed me if the reached benefits were permanent.

In spite of this, we can draw from the remaining cases not despicable teachings:

(1) The difficulty of a right diagnosis without laryngoscopy is a matter so well demonstrated that it needs no further discussion; on the contrary, I like to recollect cases in which, in spite of the laryngoscopic examination, diagnosis is not easy, particularly as regards malignant tumors, as well as those in which the microscope is not able to explain the question.

I have still under my observation a patient aged about 50, in whom the long course (three or four years), the absence of glandular swelling, of ulceration, the mobility of the cord and good general health, shut out a malignant growth; but the microscope in three examinations has not yet explained whether it is a question of a papillary or of a sarcomatous tumor.

Diagnosis is also very difficult sometimes as regards the nature of the growth; we have already seen that only a microscopical examination let me know the presence of amyloid substance, and papillomata often resemble a tubercular production.

Finally, it cannot be forgotten that laryngoscopy claims a very complete inspection; small growths at the commissure may be easily overlooked; and, in general, a persistent hoarseness is a serious token for a presumptive diagnosis.

(2) In case of benign tumors and when the voice alone is impaired, the splendid results of endo-laryngeal operations confirm that we can be, in our promises, sure and large. Fibromata, however, may in some instances require a long consecutive treatment before the voice is completely restored; and with Prof. Bianchi I retreated a case in which, after I had extirpated a fibroma (in a young, intelligent lady), there followed a complete aphonia (hystero-traumatic paralysis) which was cured several months after with suggestion.

(3) Recurrence, so constant in malignant neoplasms, so frequent in papillary growths, may be also observed in cystic and fibromatous tumors, but in these last instances constancy may triumph, particularly when opportune therapeutic measures are taken—as cauterization in case of

cystic tumors; *curettement* in papillomata, for which (when diffuse) I found temporary intubation after removal very serviceable.

(4) Tracheotomy was required in the cases which I had the opportunity to treat, twenty-six times: *i. e.*, for malignant tumors, nineteen times; for papillomata, four times (in case of children or diffuse tumors which did not show a laryngeal operation, with a complete success, removal of the cannula once with nothing else); for fibroma, one time; for cystic tumor, one time; for gummata, one time (on account of difficulty of removing the growth by endo-laryngeal way).

Excepted cases of malignant neoplasms, for which tracheotomy is done only in a palliative manner, as a duty (I can say better); the few tracheotomies which I was obliged to perform for laryngeal growths demonstrate how often we can correct dyspnoea in a more simple and quick manner.

(5) I have always employed, for laryngoscopic operations, cocaine. I can say nothing about its combination with antipyrine (one of the first to two parts of the second, in ten of water), or of guaiacol (one for twenty parts of oil), as well of the pirantine, a new substance obtained lately by Prof. Piutti.

I follow, earnestly, the practice which I learned from Prof. Labus, of Milan: *i. e.*, a saturated watery solution of cocaine, if temporarily made and directly applied, eight to ten times running. When there is no solution of the mucous membrane, there is no danger of poisoning, and I never observed the least disturbance. I was able, in this manner, not only to operate in the larynx, but reach the windpipe, if necessary.

(6) In general, I am trained with every kind of instrument, and have no pronounced preference. Fauvel's, Mackenzie's, Schlotter's forceps may have, in separate cases, advantages of the one over the other; but I cannot omit to declare that for little fibromata I employ, about exclusively, Koenig's forceps, an instrument, perhaps, not generally known, which deserves a place of honor and a more diffuse usage.

(7) I have never observed transformation of a benign tumor operated by laryngoscopic way into a malignant one. I am firmly convinced, and already expressed the same opinion, that when the clinical signs change, we are in condition to correct our diagnosis and confess our mistake; difficulties are well recognized by every expert laryngoscopist, and it is a duty for an honest physician to foresee a possible fault, even with the help of the microscope.

(8) On the contrary, I think that even in doubtful cases an endo-laryngeal operation (when possible to be performed in a satisfactory manner) is always beneficial; it can furnish a good matter for examination, a proof of recurrence, and prevent a possible transformation (I mean papillomata and adenomata); but it becomes a duty when there is direct danger, which can be surely and quickly removed and hasten a complete recovery.

Dr. Manley.—Dr. Thomas H. Manley, of New York City, will read a paper before the Tri-State Medical Society of Iowa, Illinois and Missouri upon "Morbid Anatomy of the Inflammatory Degenerative Diseases of the Peripheral Veins."

THE SURGICAL TREATMENT OF BRAIN TUMOR.*

By GEO. W. CALE, M. D., F. R. M. S., of Saint Louis.

Having made a diagnosis of intra-cranial lesion, the feasibility of an operation will depend upon: 1st, Its exact location; 2nd, Whether single or multiple; 3rd, Its size; and, 4th, Its nature. Should the tumor be situated at the base of the brain or deeply subcortical it is not at all likely to come within the pale of operative interference. If the growths are multiple (by which term I mean more than two or three located within a small area) an attempt at removal is certainly contra-indicated.

The same rule that applies to the removal of malignant tumors from other parts of the body should apply to malignant tumors situated within the cavity of the cranium.

The majority of syphilographers claim that gummata may be absorbed by means of specific treatment, which opinion is also held by Starr. Horsley denies it, and advises operation after an anti-syphilitic course of treatment, lasting not longer than six weeks. In the case of tubercular tumors, which are the kind most likely to be multiple, an operation should only be done where the patient is not the subject of general tuberculosis and where the possibility of removing the entire tubercular mass is good.

An operation having been determined upon, the entire head should be shaved: 1st, For the removal of a possible source of infection; and, 2nd, That the landmarks of the skull might be more apparent and useful.

The strictest antiseptic precautions should be taken, as the susceptibility of the meninges to septic infection is very great, and the treatment of septic meningitis is usually of little avail. The head should be scrubbed with green soap and water, then ether or alcohol, followed by the plentiful use of a bichloride solution.

To prevent the loss of blood and to keep the field of operation clear, a piece of rubber tubing may be tied around the head, passing above the eyes and ears, and below the occiput. The courses of the principal fissures should be marked out upon the scalp with nitrate of silver, and at the important points the bone beneath should be dented with some sharp instrument in order that the relationship of the parts be not lost sight of after the scalp has been raised. The old crucial incision is no longer used, but, instead, one of a horseshoe or pear shape, the pedicle of which should be toward the source of the blood vessels. The incision should in all instances extend to the bone, and the periosteum should be elevated with the skin flap.

There are three methods of opening the skull—with the trephine, the chisel and mallet, and the circular saw of Roberts, which is run by an electric motor or dental engine. The Roberts saw has this advantage: should we desire to replace the piece of bone removed, it can be cut obliquely, *i. e.*, the bone beveled at the expense of the inner table, thus securing support and preventing subsequent depression of the excised piece and cerebral compression. The chisel, in the writer's opinion, is the most exact and satisfactory instrument for this purpose (electricity for the circular saw being frequently unavailable), and while some object to its use on account

* Read before the Saint Louis Academy of Medical and Surgical Sciences. Concluded from the January issue.

of concussion, we think this objection would rarely hold good. In a large number of head operations in which the chisel and mallet were used, the writer cannot recall a single bad result from their employment. The objection would hold good only in cases of injury to the skull with resulting intra-cranial hemorrhage, where a secondary hemorrhage might be induced by the jarring of the mallet. It is well to remove a piece of bone the size of a silver half dollar or dollar, as satisfactory inspection cannot be made through a small opening, neither can the exact location always be made out. Should this be too small it can easily be enlarged by means of Rongeur forceps.

If we desire to replace the button of bone, it should be preserved in warm aseptic cloths during the remainder of the operation. After removal of all bone dust or chips, the appearance of the dura should be carefully noted—a bulging of which, into the cranial opening, indicates intra-cranial pressure, due, most likely, to one of three causes: abscess, tumor, or hemorrhage. One should also notice whether brain pulsation is present, and observe whether the dura is abnormally vascular or dull in appearance.

The absence of brain pulsation is another indication of intra-cranial pressure.

Having determined that the lesion is situated beneath the dura, it is now in order to incise that membrane almost to the full extent of the cranial opening, avoiding the blood vessels as far as possible. Should it be necessary to irrigate the wound, nothing but sterilized water or a normal salt solution should be used (except in cases of abscess), as the use of antiseptics of germicidal strength in the cranial cavity is prone to lessen the vitality of the tissues and produce foci of diminished resistance.

The tumor may be subcortical, in which case we should make an attempt to determine its exact location by palpation of the exposed cerebral mass. This being accomplished, the pia should be raised and the tumor removed with a sharp knife; or, in event of the tumor being tubercular or soft, the sharp spoon of Volkmann will be found to be the most efficacious.

Incisions into the cerebral substance should always be made parallel to the fibres of the corona radiata. If the tumor is encapsulated, its removal is usually comparatively easy. In cases of cysts rupturing during an attempt at enucleation, the parts should be irrigated and the cyst wall thoroughly dissected out to prevent recurrence. If it is not encapsulated, it is very important that the entire growth should be removed with an area of surrounding apparently healthy brain tissue, in order to be sure that none of the neoplasm has been left behind.

The control of hemorrhage, both during the operation and more especially its treatment before the wound is closed, demands our most serious consideration.

The blood vessels in the scalp, having been compressed by the rubber constrictor previously mentioned, require no further attention until the flap is to be sutured, when it will be found that the sutures can be so placed as to check bleeding completely. All bleeding points in the dura and pia should be tied immediately with fine catgut. Hemorrhage from the bone itself may be troublesome and require the ordinary methods of pressure or of plugging; if these do not suffice, the edge of the bone should be crushed with blunt forceps. Hemorrhage from the brain substance, if only slight,

can be controlled by gentle gauze pressure—which, if persistent, should be compressed by gauze wrung from hot water; it may be found necessary to allow these compresses to remain as long as forty-eight hours. Their subsequent removal should be accomplished with the utmost care and gentleness to prevent a recurrence of the bleeding, and the strictest antiseptic precautions should be observed to prevent infection.

If the hemorrhage from the brain substance is too severe to be checked by pressure, we should resort to the use of horse-hair ligatures passed deeply into the substance of the brain by means of an aneurysm needle and tied.

It must be remembered that the slightest intra-cranial hemorrhage, if continuous, will not only cause a recurrence of the pressure symptoms which were present before the removal of the tumor, but death from compression. Several such cases are on record.

The thermo-cautery has also been used for this purpose, but is to be avoided, if possible, on account of the liability of the burned tissue to suppurate. In cases where hemorrhage has to be checked by the thermo-cautery, it is always necessary to use gauze drains for several days. Tubes or catgut may be used instead of gauze for drainage. To complete the operation the dura should be sutured with fine catgut, and the skin flap secured with silk-worm gut or silk, a few strands of catgut being placed between the dura and periosteum, if no other drainage has been employed.

Cases have been reported by Horsley, and others, where the operation of trephining was followed by relief of the symptoms where it was not possible to remove the tumor, and again where no tumor was found, either at the operation or the post-mortem made several months later.

The result of operations for brain tumor are far from what we might desire.

The following tables, published by Dr. Starr in the *Medical Record*, serve well to show the unsatisfactory state of brain tumor surgery:

TABLE OF RESULTS OF OPERATIONS FOR BRAIN TUMOR.

	CEREBRAL.	CEREBELLAR.	TOTAL.
Total number of cases operated upon for brain tumor	137	25	162
Cases in which tumor was not found.....	39	9	48
Cases in which tumor was found but not removed	5	2	7
Cases in which tumor was removed and patient recovered.....	65	7	72
Cases in which tumor was removed and patient died	28	7	35

TABLE II. VARIETY OF TUMOR REMOVED AND RESULTS—1893 to 1896.

VARIETY.	RECOVERED.	DIED.
Sarcoma	10	5
Glioma	3	1
Glio-sarcoma	2	0
Cystic	3	5
Tubercular	3	3
Gumma	1	2
Fibroma	0	1
Angioma	1	0
Not stated	3	4
	<hr/> 26	<hr/> 21

THE VARIOLIFORM SYPHILIDE.*

By A. H. OHMANN-DUMESNIL,

Professor of Dermatology and Syphilology in the Marion-Sims College of Medicine,
St. Louis.

AMONG the more common eruptions of syphilis may be mentioned those which are pustular, and they are particularly interesting from the fact that there are so many cases seen daily which are characterized by pustular eruptions and still are not specific in character. If for no other reason than this, it will occur to any one that a proper appreciation of the pustular syphilides in general, and of the varioliform variety in particular, is of the greatest value to the physician who is engaged in general practice. It is a proper appreciation of special forms of any general class of eruptions which makes any one proficient in differentiating, as well as recognizing all, and by careful study as well as thorough observation and examination, such a power can be easily acquired and a practical application thereof made in any case which may present itself. As has been already stated in former articles, already published in the TRI-STATE MEDICAL JOURNAL, syphilis is a disease which is protean in the forms which it assumes; a close simulation of other diseases is affected by this process, and this simulation is often so close as to lead the unwary observer to make an error which may be costly, not only to the patient, but to the reputation of the physician as well. But, perhaps, a detailed description of the eruption under consideration in connection with those of other forms of pustular syphilides may serve to give a more complete idea of the various descriptive points, and thus lead to a better appreciation of the differential points in connection with each.

The varioliform syphilide is one of the interesting forms of the pustular syphilitic eruptions which we have occasion to observe. In this form of secondary syphilis there exists a number of modifications in so far as the form of the lesions, their number, their distribution, their size and their evolution are concerned. It is an eruption which, when fully developed, is apt to prove more or less puzzling to the inexperienced examiner, more especially if, as is but too often the case, he is satisfied with an examination of but a limited portion of the integument. It is for this reason that a complete examination should be insisted upon, as the *tout ensemble* will often easily determine that which a limited surface would not easily reveal to one who is inexperienced. A mistake which beginners are apt to make is to attempt a rapid diagnosis from the examination of a few lesions, because they have seen experts do so. The skill permitting of such a rapid diagnosis has been acquired only after the careful examination of many cases and an acquired familiarity of lesions which long study and close observation alone can confer. It is, at best, a rather difficult matter to acquire dexterity in such matters, even under skilled teachers, so that it can be easily understood how much more difficult this matter becomes when reliance must be placed upon mere descriptions and pictures.

* Read before the St. Louis Academy of Medical and Surgical Sciences.

Another point to bear in mind is that the same form of eruption will vary in different individuals, sometimes in so marked a degree as to lead to the very natural supposition that it is not one and the same eruption that is being dealt with. And yet a proper study of the characteristics presented, will readily clear up any doubts and dispel any clouds which might tend to obscure the certainty which should attach to a diagnosis. The inability to make a correct diagnosis, no doubt rests in great part upon the inability, which so many unfortunately possess, of properly and completely appreciating form, contour, shape, size and distribution, as well as a lack of properly discriminating color, more especially so far as the various shades of red are concerned. In addition to this there is too much proneness to place reliance upon the truthfulness or exactness of a patient's answers to questions put to him. One of two conditions is apt to present itself. The patient may be very ignorant and, with the best will and most earnest desire, be incapable of furnishing any information likely to be of any value. On the other hand, he may perceive or perhaps believe that his questioner depends, in a measure, upon the accuracy of his answers. By some unexplainable perversity he will set himself to willfully deceive his interrogator, in the hope that he may conceal the true nature of his disease, whilst ignoring the fact that in case he did succeed he might injure himself irreparably by thus withholding valuable information. There is no class more prone to attempt this sort of deception than women, and, unfortunately, they succeed but too often in their efforts, thus adding to the sum of their future troubles by their ill-directed reticence. The physician should listen to the histories of suspected cases with many qualifications in regard to accepting them without question. He should ever keep in mind the celebrated saying of Solomon, that "all men are liars," and not forget that this is more particularly true in reference to syphilitics and morphinomanics. On the other hand, too much incredulity or doubt should not be indulged in, as such a course might lead to fatal errors. An exact appreciation and accurate knowledge of the objective lesions presented will prove most valuable guides in the proper judgment of whatever history may be given, and if the examination be properly conducted, enough information can be gained to make a case well understood and the proper course to pursue clear.

The varioliform syphilide is one of the interesting forms of the eruptions occurring in syphilis, from the fact that it bears a very slight resemblance to variola, when the lesions of the latter have passed through the stage of suppuration and umbilication. Like all syphilitic eruptions it does not itch, and it is in reality nothing more than a peculiar modification of the pustular syphilide. Whilst it is not of common occurrence, it is so with sufficient frequency to deserve more than a mere passing mention, and it should always arouse a certain amount of interest. It may occur during the earlier period of secondary syphilis or it may show itself at a later date. It may be stated, in general terms, that it manifests itself at about the same periods at which the pustular syphilides do, although it is almost rare to observe it as a very late pustular manifestation on the integument.

An excellent representation of the syphilide under consideration is given in Figure 1. The history of the case, whilst not as satisfactory as it

might be, may be briefly summarized as follows: X—, male, a mechanic, aged 21; has always enjoyed good health and has been steadily working since he was fifteen years of age. He has never had an illness during this time. Whilst not heavy in weight, his muscular development is good,



FIG. 1. Varioliform Syphilide—Small Form.

and he still continues to work. He presented himself for treatment August 7th, at which time he manifested the appearance shown in the figure. As far as could be satisfactorily determined, the infecting connection occurred about March 24th. Three weeks later the primary lesion, or chancre, made its appearance. This gave him very little concern; but May 3d, or

about five and one-half weeks after the suspicious intercourse, a large bubo was observed in the right inguinal region. As fluctuation was present, it was incised and profuse suppuration established itself. The scar which followed the incision may be dimly perceived in the illustration. An eruption appeared July 1st, or about thirteen weeks after the appearance of the chancre. No definite description of this eruption could be elicited, so that its true character could not be determined. There is no doubt that there was a precedent which probably escaped attention. The eruption when seen and observed by the writer existed upon the back, the chest, in the right groin, on the scalp and the forehead. The induration of the chancre could still be determined at the former site of the lesion, a circumstance which is not surprising in view of the fact that there had been no treatment of the disease whatever.

A careful examination of Figure 1 will show a number of points of interest. The eruption is a distinctly pustular one, as can be readily perceived. As can be readily seen the lesions vary in size from a pin's head to that of the little finger-nail. In the majority a distinct umbilication may be noted, and it is this characteristic which has earned its name for this particular syphilide. Each lesion is surrounded by an areola of a moderately bright red color, which is larger, or rather broader, about those pustules whose size is greater. The umbilication wherever it exists is not very deep, but it is conical in form; that is, it resembles an inverted cone. The lesions have the appearance of being rather flattened on account of the sinking of the apex, and it may be further noted that the younger and smaller pustules still retain their conical form. Taken altogether, the variety of pustular lesions is such as to arouse more more than ordinary interest, and in order to justify its name the eruption must have a preponderance of umbilicated lesions.

In the case under consideration the distribution of the eruption was discrete over the chest, although rather more marked upon the left side. A pronounced patch of smaller lesions existed over the *mons veneris*, and in the left inguinal region, the right being perfectly free. Here and there scattered pustules could be found on the arms and legs. The back was the seat of quite a discrete eruption, there being less lesions than on the chest. Upon the face, only a few pustules could be found; whereas, on the forehead, quite a number existed. This last peculiar distribution is one which has elicited much attention, from the fact that it occupies a favorite site of acne. When no distinct umbilication of the lesions exists, it is known as the acneiform syphilide. In any case, when the forehead is the seat of a syphilitic eruption, the patch has been given the appellation of *corona veneris*, or crown of venus.

In the case which is shown in Figure 2 we have the same variety of eruption, with a certain number of differences, however, which tend to show the protean manifestations which the disease is apt to manifest, and may account for the difficulty experienced by so many practitioners in the formulation of a correct diagnosis. In that form of the varioliform syphilide, which we propose to consider, it will be seen at first glance that the lesions are of a comparatively large size. Whilst in the form described above the pustules are of the size of a large pin's head, in this their dimensions are at least twice as great in diameter. As a natural result, the same rule

holds as in all cutaneous eruptions—the distribution is much more discrete. For it may be held, as a general rule, that the larger the lesions the smaller they are in number. A further peculiarity to be observed in the case pre-



FIG. 2. Varioliform Syphilide—Large Form.

sented is that it is principally the thighs which are implicated, the abdomen having but a very few, sparsely scattered, small lesions; the same condition existing upon the chest. This is not all, however. In that variety of the varioliform syphilide in which the eruption is composed of the smaller

variety of lesions, it is a comparatively early manifestation of the secondary stage. In that form in which the large lesions predominate, we find it manifests itself at a comparatively late date after the primary infection, and the evidence of this is furnished by the apparently healthy appearance which the point of infection—the penis—presents. The further fact of a late appearance accounts not only for the larger size of the lesions, but also for their relative paucity in number.

The lesions themselves, when critically examined, will be found to present the general appearance of large papules of a rather dark red color, and sharply defined against the skin, showing but a slight small umbilication. The pus at the center, however, shows up brightly and is well defined, the contour of the purulent deposit being round and the purulent mass covered with a slight thin pellicle, which bursting will give free escape to the contents. This is followed by a crust which is but slightly adherent. This crust, however, is rather small in size, but apt to be comparatively thick. So far as subjective symptoms are concerned there is neither pain nor itching to be located in the skin. It is not an unusual thing, however, for the patient to call attention to deep-seated pain in those bones which are situated subcutaneously. These pains have the peculiarity of being most marked at night, the time when they seem to recur regularly. These osteocopic pains, which are far from uncommon in this variety of the varioliform syphilide, are simply the manifestations of an implication of the deeper tissues, and are further evidence of the lateness of the process. Moreover, they constitute a most valuable indication and guide in regard to the course of treatment which should be pursued. However, as a general rule, we do not encounter these manifestations of periosteal and bone lesions as apparent at this stage of the disease; and, unless they be of an accentuated character but little attention need be paid to them.

So far as the differentiation of the varioliform syphilide from variola is concerned, it should offer no difficulties. In the first place, we have the history and, in the early form, the presence of the chancre or its remains and the consequent adenitis. In the late form there can always be seen some indubitable concomitant symptoms as well as a history of former eruptions. Again, lesions in various stages of development can be made out, and in syphilis no vesicles can be seen. The periods of incubation of the eruptions are entirely different, as well as the evolution of the individual lesions. The intense backache, headache and fever of variola are not observed in syphilis, although a marked headache is not unusual, but it is prone to localize itself, whereas in variola it is generalized. The eruption of variola has for its sites of election the wrists, chest, and face; more severe cases involving the entire body. The eruption makes its first appearance in the form of dusky papules, not much elevated but feeling like shot under the skin. In the varioliform syphilide, pustules at once declare themselves and have no particular localities in which they first make their appearance. In variola, itching is a marked symptom; whereas, its absence is noted in syphilis. A large number of points of difference in the evolution of the two diseases might be noted, such as vesiculation, umbilication, and pustulation in variola, in the order named; and simultaneous umbilication and pustulation in syphilis; but a sufficient number has

been adverted to to render it a comparatively easy matter to establish a correct diagnosis.

In the treatment of this eruption a certain amount of watchfulness is necessary, and it should be rather energetic in order to be able to procure a good result in a reasonably short space of time. It is of some importance to make the treatment active, not only to make the eruption disappear rapidly, but so as to prevent relapses and obtain as rapid a modification of the tissues as possible, and thus prevent an aggravation of the process in the existing lesions as well as mitigate the destruction which always accompanies the pustules, as is evidenced by the scars which follow. In order to produce a good effect the following will be found of service:

℞ Hydrargyri bichloridi gr. iv
 Kali iodidi ℞ ss
 Aquæ destillat ℥ iv
 M. Sig. Teaspoonful in milk after each meal.

When this mixture cannot be well tolerated by the patient, the following is often well borne:

℞ Pil. hydrarg. biniodid., aa gr. ¼
 No. 50.
 Sig. One pill after each meal.

In case the above produce diarrhœa, gastric irritation, or some similar untoward effect, recourse may be had to the following:

℞ Pil. hydrarg. tannici, aa gr. j
 No. 100.
 Sig. Two pills three times a day.

When a sufficiently long mercurial course has been taken iodide of potassium may be given, and its unpleasant effects mitigated by combining wine of kola with the solution.

The local treatment of the varioliform syphilide differs somewhat from that of the small pustular syphilide. It should be rather more active, just as it is in the large pustular form, for several reasons. In the first place, the process is one in which there exists a greater or less destructive tendency, from the fact that the suppurative process frequently attacks the true skin and, as a result of its partial or complete destruction, scars will follow its disappearance. Furthermore, it is possible for the process to extend to such a degree as to result in the formation of ulcers. These reasons are certainly sufficient in themselves to demand and require care and serious attention to the local treatment. A good, albeit tedious method is to open each pustule and empty it of its contents as well as this may be done without pinching or bruising the lesions. The entire eruption is then washed with a lotion composed as follows:

℞ Hydrarg. bichloridi gr. iij
 Ammon. muriat. gr. vj
 Aquæ rosæ ℥ viij
 M.

Immediately after the application of this wash, the following ointment is to be applied to each lesion:

℞ Hydrarg. oleat. 3% ℥ iij
 Ung. hydrarg. ciner. ℥ v
 M.

The ointment should not be rubbed in too strongly, but rather lightly passed over with the finger once or twice. Following this campho-phenique

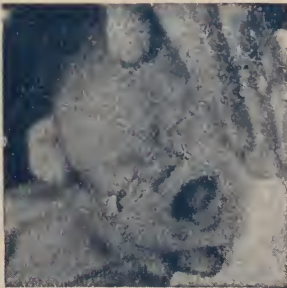
powder is liberally dusted over the whole surface. The entire procedure should be followed once a day and, if faithfully carried out, in a few days the eruption will have been a thing of the past. After the lesions have disappeared, it will be found to be a good idea to continue the applications of the bichloride solution, as this will obviate, to a great extent, the occurrence of pigmentation.

DERMOID TUMOR OF THE EYE.

By H. G. THOMAS, M. D., of Oakland, California.

THE following case was brought to my notice by Dr. Hester A. Hewlings, of East Oakland. Baby Peterson was the proud possessor of a rather unique dermoid tumor when he first saw the light. The base, of funnel shape, reached from the temporal one-sixth of the cornea to the outer canthus, and from upper to lower fornix.

The child was four weeks old when brought for operation. After chloroforming, I introduced the stop speculum, and pulling the tumor out taut, found that the base, instead of spreading from fornix to fornix, came up as a thin band from the cornea to the outer canthus. The portion outside the lids was of the usual skin formation and covered with very fine



Natural Size.

hairs. I passed three sutures just under the well-marked line between the base of the tumor and conjunctiva, and after dissecting the corneal portion off with the angular keratome, removed the rest with the scissors. The tumor was very vascular, quite a fair sized artery being divided. The hemorrhage was controlled by pressure, and the conjunctival surfaces brought together by the sutures previously introduced. Healing was prompt and uneventful.

These tumors are usually small, sessile, and nearly always to the temporal side of the cornea, and are congenital. Some ascribe them to amniotic adhesions, others to a coalescence of the lids, which on parting leave a fragment. Both are guesses and we are left to take our choice.

A New Book.—Dr. Howard A. Kelley has in press a *Treatise on Gynæcology*, on which he has been at work for some time. From the popularity of the author, and his reputation as a gynæcologist, the book ought to take well.

A MEMOIR ON THE ODORIFEROUS SENSE.*

By J. MOUNT BLEYER, M. D., F. R. A. M. S., of New York City.

MAN is, in a certain sense, the slave of his nose, and even a strong will is often powerless in its struggle against the force, partly original, partly developed by habit, of that unseemly tyrant. Not to be suspected of a trivial allusion to the snuff-taking members of mankind, and in order to allay in my readers every sentiment of indignation which this imputed slavery might give rise to, I hasten to explain and prove my assertion, stating at the outset that we share this slavery with the animals, to which we, in general, and even in many a physical relation, are certainly now incomparably superior as the proud lord of creation would fain believe. Who would deny that what we call our disposition is but a soft wax, moulded in manifold ways by sensual impressions, and, according to their nature and power, incessantly changed into endlessly varying shapes, comparable in this respect to the photographer's plate, which, yielding to the influences and inviolable laws of light and shadow, reproduces in faithful images the local relations under which light and shadow act upon it? Who, indeed, would be so presumptuous as seriously to assert himself complete master of his disposition, and able to force it to withstand the most powerful impressions of the senses, without changing color or form? He who asserts this has not yet cast a profound discerning look into the machinery of his own mental life, whether prevented by a lack of talent for self-observation or by a lack of modesty. He who earnestly examines and tries to understand his inner life, will have found that, in a thousand cases, our longings, our desires, as well as the opposite antipathies, always bear the color of the momentary disposition; that, as its effluences, they are, like itself, the indirect products of the workings of the outer world upon our soul through the medium of our senses; and that from the same source flow thousands of our actions which we regard as entirely spontaneous, as springing from our free will, and not from the force of external influences. These may appear to some as commonplace speculations; they certainly are truths which the lyric poetry of all ages has hounded to death and which, coated with new phrases, are reproduced in every novel; but they are, no doubt, nevertheless obscure to many a reader who receives them with a contemptuous smile as stale, and in a given case deceives himself, unable to discern the source of his disposition, the hidden external causes which, through the senses, have necessitated his "voluntary" desires and actions. We shall leave it to the poets to sing the commanding voice with which nature speaks to our soul through the senses, churning forth in varied alternation, joy and sorrow, longing and horror, and only in a few allusions shall allow ourselves a slight encroachment upon their domain. Whose heart is so ice-bound as not to be warmed by the charms of nature awakening from its slumber on an early and a serene spring morning? Behold! its youthfully stirring life pours into your inner being through all your senses, paints every thought with its gaudy tints, rouses all the

* Annual paper read before the Société Française D'Otologie, De Laryngologie et De Rhinologie, of Paris, 1896.

merry spirits of your heart (an innocent instrument, indeed, but which the poets have transformed into a cornucopia of the feelings). The fresh and sapful verdure excites your nerves of sight, the tepid air your nerves of touch, the fragrance of the young spring flowers your nerves of smell, the returning birds your nerves of hearing, inspiring long-missed sensations, and if you so want it you can procure a vernal enjoyment even to your nerves of taste. And what is there in that verdure, in that fragrance, in that soft breeze that so works upon our soul? Why is the green carpet enabled to breathe into our heart a desire for traveling, or to stimulate that secret longing so often sung by the bards of spring? Physiology has no better answer to these questions than poetry, but in these and other innumerable facts it sees evidences of the normal dependence of the actions of the soul upon the qualities of the physical processes in the excited nerves, and the processes of sensation unavoidably conditioned by the former. In other words, the outer world compels our soul not only to feel, but, indirectly, also to think, to form conceptions, even to will, and thus leads, as if by a thread, that proud being that fancies to walk in such unconditional independence of the laws of the physical world. What a poor thing would the human soul be without the senses; nay, it is not even imaginable without them. A man born without any senses could scarcely vegetate; it would be absurd to talk of his *living* psychically. The soul develops its abilities only in the school of the senses; only the senses convey to it the materials for thinking, for the formation of conceptions and ideas; only the senses give it the primary objective points for the development and exercise of its volition; the will, even if an imminent and inborn faculty of the soul would, without the senses, be a latent force. I leave it for you to picture to yourself what I have only hinted at, to form an idea of the spiritual activity of a man cut off from all sensuous perception. After an unprejudiced examination everybody will arrive at the same result, at the conviction that psychical life without senses is to us something entirely inconceivable, the best proof of which is that at every attempt to imagine the soul surviving and separate from the body, we are compelled to endow it with senses and the ability of reacting upon external bodily things, else our attempt fails from the beginning. The *instinct*, however, of forming such an image is necessary, and deeply rooted in the human soul, educated as the latter is under earthly circumstances, from which it borrows all its conceptions; no one can free himself of that instinct.

In short, the soul, in its earthly career, is first the pupil and subsequently, through life, the slave of the senses, inseparably connected with them as the steam-engine is with the fire which engenders its motive power and renders its activity possible. Deprive a grown-up person, who from childhood has been in full possession of all his senses, of only one of them—the sense of sight, for instance—and observe how poor his educated soul becomes through this single loss, how narrowed its circle of ideas, how one-sided the exercise of its volition; deprive him of several, and see into what pitiable poverty even the richest soul will sink.

It is true the sense of smell is, of all, the least necessary; and still it is a tyrant, like the others, and plays its part as such openly or behind the scene. It, too, moulds our disposition, awakens desires—most material

desires, too—and these are followed by actions which, when speaking of man, we boldly designate as entirely voluntary (because they can be prevented by our will); and when of animals, we put to the account of that universal wizard called instinct. Here are a few examples: You speak of an innate instinct when the hound follows the track of the game, which his extremely keen sense of smell makes him discover; you justly deny this action of the dog to be an entirely voluntary one, caused by reflection. When, your stomach being empty, the delicious odor of a savory meal engenders in you an appetite, that is to say, literally, a desire for that meal, and you satisfy this desire; when the drunkard, seduced by the vapors of spirituous liquors, yields to the tempting odor, in spite of all his good determination and of energetic exertions of the will to prevent it, and satisfies what he emphatically calls his thirst. I do not see what difference there is, from a physiological point of view, between your and the drunkard's case and that of the hound. Like the latter, both of you obey the incitement produced by the nerves of smell; in most cases, it is true, you can refrain from satisfying your desire, but just of this desire you cannot free yourself, whether you be one of the strong or the frail. When the new-born child grasps at its mother's breast, and tries to suck it, as it also does with every finger offered it, you cannot avoid supposing a human, in-born instinct, and attributing to it that inconceivable action so beneficial to the child. The grown-up man who grasps at the *odorous meal* differs from the new-born child only in that he understands his action; the desire itself, and the action resulting from it, are as necessary consequences of the working upon the soul of the singularly excited nerves of smell, as is the child's grasping at and sucking its mother's teat. The slavish dependence of our soul upon the impressions of the sense of smell is very clearly evinced by the well-known fact that the same food, the flavor of which seems to us delicious, and invites us to eat when we are hungry, disgusts us at a state of satiety, so that the strongest will can scarcely induce us to eat of it. The replenishing of our stomach and the saturation of our blood with nourishing matter so much changes the disposition of our soul that it *reacts upon the impressions* of smell in a quite opposite way to its action in hours of hunger, and obstinately rejects what it previously desired, commanding our organs to convey it to the alimentary canal. We say we want to follow no more the odor of the food when we have eaten enough; but this freedom of will is not a bit better than that of the fox who did not want the unapproachable grapes—than that which makes us grasp after food when hungry.

How slavishly bending and wincing does our disposition follow the lead of the nose in its various smelling exercises! A habitual smoker is a hypochondriac when deprived of his cigar; with the smoke he scatters his grief and cares to the winds; the flavor of coffee opens the sluices of eloquence and all the gates of the heart to the matron; while the tender fragrance of flowers charms forth a thousand sweet emotions in the souls of the maidens; the smell of a corpse oppresses our breast and fills us with horror, just as the odor of balmy incense inspires us with pious exhalation. A profound recognition of this dependence of our disposition upon the impressions of smell is involved in the superstition of the ancients who sought to propitiate their gods, whom they imagined to themselves purely

human, by the odor of burned sacrifices, which odor, of course, we would not include among the pleasant ones—a superstition which even now, though in an altered form, finds its expression in the incense burnings of the Catholics.

How often does it happen than an accidental impression of smell, such as we remember having felt another time under certain circumstances, becomes the cause of a long migration of the soul through the events of the past, deploying before us a long series of pleasant or gloomy pictures, and thus determining for a time the activity of our soul. But these physiological sketches may suffice; in drawing them we had no other object in view than to awaken that mysterious influence which so powerfully rules our spirit. Unfortunately, however, the physiology of the sense of smell still occupies an exceedingly low place, considerably below that occupied by the physiology of the other senses, so that we can satisfy that desire only in a very imperfect degree.

We not only have no idea of what passes in the nerve of smell while it produces a sensation of smell in the brain, no idea of the way in which that nerve becomes affected in the membrane of the nose, but we have also not the slightest knowledge of the external irritation which causes that affection, or of the qualities of substances which renders them odorous. While, as regards the senses of sight and hearing, and also that of touch, we possess the exact physical knowledge of the external agencies which the nerves of the eye, of the ear, and of the skin react upon; while the laws of the oscillations of the luminous ether, of the velocity and extent of its waves, of the vibrations of sound, etc., have been elucidated with wonderful acuteness, neither physics nor chemistry answers the questions, what agent excites the nerve of smell? by what force musk or ether of rose-leaves acts in this or that specific way upon the organ of smell? why the oxygen of the air, a gaseous substance like the strong-scented musk vapor, is odorless.

Unfortunately, my very beginning must be with a negative truth. We do not know what a *sensation of smell* is, just as we are unable to explain and describe the nature of a sensation of touch, sight, hearing or taste. Those conscious *conditions of the soul*, which we call sensations, defy all definition. Let one try to describe the fragrance of a rose, or the scent of musk, or what we call a spicy odor, or a putrid smell, or to tell what distinguishes the scent of a violet from the smell of putrescent meat. Indeed, this is a problem which admits of no solution; everybody knows how a violet smells, everybody preserves in memory the often-felt nature of that sensation of smell, embodying it in imagination and recognizing it even when the sense of sight does not present a violet as its apparent cause, but none is able to designate any characteristic mark of that sensation, distinguishing it from the nature of other similar ones. The designations which are used are, therefore, all borrowed from the external causes; they either directly name the object from which an odorous substance is evolved, or which is itself odorous in a gaseous form (smell of roses, smell of oil of roses), or they are selected in accordance with qualities and conditions under which external objects become smellable (putrid scent, *roast smell*). When one enters a scented atmosphere, and, without knowing the object which makes it so, desires to describe his sensation, he cannot do it with-

out mentioning some object which, on a previous occasion, caused in him a sensation of smell of the same quality, and therefore it can be said it smells like violets, like varnish, etc. Sometimes we recollect only having experienced previously a similar odor, without our memory having also preserved its cause, and in such cases we stand there helpless, completely unable to designate to any one the character of the sensation of smell produced in us. That we are still less able to compare a sensation of smell with a sensation of another sense—with a sensation of light or sound, for instance—hardly needs an elucidation. Not even sensations of smell and taste, or of smell and touch, which, as I shall show the uninitiated, are so prone to mix up with each other, can in any way be compared with one another, however paradoxical this may sound. We speak, for instance, of the keen and pungent smell of spirits of sal ammoniac, and yet the sensation thus designated as keen and pungent is no sensation of smell at all, but a so-called *common sensation*—a sensation of pain produced, not by an affection of the nerves of smell, but by an irritation which the vapors of that substance cause in the fibers of the nerves of touch spread through the mucous membrane of the nose—a sensation which has nothing in common with the true sensation of smell *simultaneously* produced by the same substance. We mistake it for a sensation of smell, because it simultaneously arises with one of that sense, and because we find that, like the latter, it comes from the nostril; not every one knows that the sensation of smell is produced in the upper parts of the mucous membrane of the nose, and the sensation of touch in the lower. Physiology, however, can prove with certainty, by experiments and observations and sick persons, that all the presumed acute burning, itching, or pungent sensations of smell are brought about, not by an excitement of the real and exclusive nerve of smell, but of the same nerves which, when gently touched, produce a ticklish feeling. There are individuals who do not feel the scent of either roses or violets, because their nerve of smell has been deprived by disease of its active faculty, but who, nevertheless, are very well accessible to the pungent sensation caused by the vapor of sal ammoniac rising into the nostril. Everybody knows, from personal experience, that when deprived of all smell by a severe cold—that is, when in consequence of an inflammation of the mucous membrane of the nose, smelling substances have ceased to act upon the extremities of the nerve of smell, he is still accessible to the acute sensation caused by spirits of sal ammoniac or mustard, just because this sensation is produced by the vapors of these substances penetrating the nerves of touch. On the other hand, it also frequently happens that we mistake a sensation of smell for one of taste, because the two happen to coincide. Thus, we speak of the aromatic taste of a substance which has an aromatic scent; while we have the substance on our tongue, deriving from it a real (bitter or sweet, etc.) sensation of taste, vapors from it also enter our nasal cavity, which by the throat is connected with the mouth, and there produce the aromatic sensation of smell.

As this latter coincides with a real sensation of taste, as well as a sensation of touch on the tongue, which makes one believe the cause of the sensation to be within our mouth, while there is no distinct indication of the nasal seat of the sensation of smell, we place this too in the oral cavity, mistaking it for a sensation of taste. Many a *connoisseur* of wine may,

indeed, be surprised to hear that while tasting that liquor or wine his nose is as actively engaged as his tongue; that his praise or *blame* is being determined by smell no less than taste all the time he, with closed eyes and all kinds of grimaces, moves the noble juices of wine to and fro on his tongue.

In spite of much earnest reasearch, very little is yet known of the organs of smell. A sensation of smell takes place when a certain nerve, called the nerve of smell, or olfactory nerve, which rises in the brain and spreads its extremities through the nose, becomes affected by a gaseous smelling substance; that is to say, when the process which is called the "nervous current" is produced in that nerve, rapidly extending from the seat of affection, the mucous membrane of the nose, along the fibers of the nerve to the brain, where, by means of a peculiar apparatus, it acts upon the mind. In itself the nerve of smell is a nerve like all others; its fibers have the same appearance, the same qualities, as the nerves of touch or sight, or even as a muscle nerve, the current of which in the muscle produces contraction, and through it motion of the limbs, etc. Even the current which in the nerve of smell rushes to the brain while conveying a sensation of smell is, as we have seen, very probably essentially like the current in the fiber of the nerve of sight, by which this produces a sensation of sight; or like the current in the fiber of the motive nerve which, spreading from the brain to the extremity of the fiber, acts upon the muscle and causes a compulsory contraction. What, then, constitutes this nerve, essentially the same with all others, a nerve of smell? What explains, notwithstanding this identity with other nerves, the specific kind, incomparable with others, of its faculties? Similar reasons to these which explain why the same copper wire, with the same electric current, now moves the hand of a clock, and now ignites powder, etc.; that is the nature of the apparatus at the extremities of the nerve of smell in the mucous membrane of the nose and in the brain. In the mucous membrane of the nose we must suppose some specific apparatus arranged at the extremities of the nerve fibers by which a current is produced in the fibers by a smelling substance; in the brain we must suppose apparatus at the extremities of the same fibers in which the current causes a specific process, still entirely unknown to us, out of which the soul forms a sensation of smell. This is the general answer which we have previously attempted to establish; a special answer in regard to the nerve of smell we can, as yet, give only in the most imperfect way. In vain search has been made with the microscope for apparatus at both ends of the tender fibers of this nerve, the mechanism of which would be so visible to us that we could explain by it the action of the nerve of smell and its difference from the action of other nerves. With astonishment there has been discovered at the extremities of the brain the same small grainy dark vesicles (nervous cellules) which are also found on all other nerves of sense. None of the powerful means of discernment of physiology gives, as yet, the entire clue to the process which the nervous current produces in these vesicles; by what that process is distinguished from one taking place in the vesicles of the nerve of sight; and still less an answer to the question how this process can work upon the soul and force upon it that sensation which we call a sensation of smell. We do not fare much better when attempting to

analyze the external extremities of the same nerve. It is only a short time ago nothing more could be stated than that its fibers probably ended in free points on the fundamental tissue of the mucous membrane of the nose, which tissue is precisely like that of every other membrane. No mention was made of separate apparatus, the necessity of the existence of which the physiology of the time did not apprehend. It is only a few years ago, however, that a philosopher of great merit took an important step in advance, by showing the formerly presumed but not seen extremities of the nerve fibers, and by proving the existence of peculiar elements of tissue at those extremities.

[TO BE CONTINUED]

FORMULAE.

Palatable Castor Oil.—A palatable emulsion of castor oil may be prepared as follows:

℞ Powdered acacia.....	ʒiv.
Castor oil.....	fl. ʒj.
Elixir of saccharin.....	mxxx.
Oil of almonds (bitter).....	mj.
Oil of cloves.....	mij.
Distilled water to make.....	fl. ʒij.

Dissolve the gum in sufficient water and add the oil gradually; lastly add the flavoring.

Glycosin, saccharin and dulcin are all soluble to some extent in castor oil, and are serviceable for imparting a sweet and pleasant flavor, masking to some extent the disagreeable taste of the oil.—(*London Practitioner*).

Chapped Hands.—The following is the formula of an ointment which is said to be useful for chapped hands:

℞ Menthol.....	1 part.
Salol.....	2 parts.
Olive oil.....	2 parts.
Wool fat.....	60 parts.

To be applied to the hands twice a day—night and morning.—*Ibid*.

Frost-Bite.—The following applications are recommended for the relief of frost-bite: One drachm of diluted hydrochloric acid may be dissolved in a three-ounce emulsion of acacia, or ichthyol may be used in varying strengths, either in watery solution or in the form of ointment.—*Ibid*.

Sulphate of Soda as a Hæmostatic.—J. Reverdin, of Geneva, states that he has often used with success sulphate of soda in small doses ($1\frac{1}{2}$ grain every hour) in grave capillary hemorrhages, spontaneous or traumatic. The method is said to have been first employed by Kussmaul in hæmophilia. Reverdin has made experiments to ascertain the mode of action of the remedy—given to animals (rabbits, guinea-pigs), mixed with their food, or by intravenous injection, it seemed to render more rapid the coagulation of the blood; used hypodermically it had not the same effect.—*Ibid*.

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THE COMING MEETING OF THE TRI-STATE MEDICAL SOCIETY.

April 6, 7 and 8, 1897, the Tri-State Medical Society of Iowa, Illinois and Missouri, will meet in Saint Louis under favorable auspices. The success of the meeting is already assured from a scientific standpoint, for the program is an excellent one, to which many of the foremost physicians and surgeons of this country will contribute. Doctor Joseph Price, of Philadelphia, will hold an interesting surgical clinic; Doctor James T. Whittaker, of Cincinnati, one of the foremost American clinical teachers, will give a medical clinic; Dr. J. Mount Bleyer, of New York City, will demonstrate the usefulness of the new X-ray photography in the diagnosis of thoracic diseases; Doctor Dudley Reynolds, of Louisville, will hold an ophthalmological clinic, and the papers to be read will all be excellent ones. A very large attendance is expected. When the Society met in this city two years ago, every one voted it a huge success. Probably the coming meeting will surpass any ever held by this young and progressive Society.

A special feature of the meeting will be the excellence of the exhibits by pharmaceutical houses, instrument dealers, etc. The sessions of the Society will be held in the Medical Hall of the new Holland Building, Seventh street, between Olive and Pine. An entire floor will be occupied by the exhibits. Of late years these have become a useful and necessary part of every large medical gathering. They afford the physicians,

particularly those who live in small towns and in the country, an opportunity to become familiar with the latest and most elegant products of modern pharmacy. The latest appliances in the surgical armamentarium and the newest medical books are also to be seen at such gatherings. Often the information thus gained is of the greatest value to the physician in assisting him in his daily duties. Particular attention, therefore, will be given to the exhibits at the coming meeting.

A feature of the meeting will be a "smoker." Doctor G. Frank Lydston, of Chicago, will tell one of his characteristic stories and there will be a full bill of specialties.

There will be no formal banquet, owing to the fact that banquets generally interfere with the scientific part of the program. A number of the Saint Louis doctors will entertain their friends in an informal way and without detriment to the program. We understand that the address of welcome on the part of the local profession will be given by that well-known gentleman, Dr. Elisha H. Gregory, ex-President of the American Medical Association, and one of the kindest and ablest members of the local profession.

The clinics will be held in the City Hospital.

AN IMPORTANT RESOLUTION.

The Saint Louis Academy of Medical and Surgical Sciences recently listened to an able paper by Dr. Emory Lanphear, upon "A Preliminary Report on Fifty-Cent Hospitals," in which the author exposed the inner workings of those numerous cheap institutions of this city. After a thorough discussion of the subject, the Academy resolved that no member could be in good standing who had any connection with the fifty-cent hospitals. The resolution was passed without a dissenting voice. This places the Academy squarely on record.

We understand that the ethics of the matter will be discussed in the Saint Louis Medical Society at an early date. Doubtless, it will be an interesting discussion, since a number of the fifty-cent doctors are members of the Society.

DOCTOR LYDSTON'S VIEWS.

Doctor G. Frank Lydston, of Chicago, is an original thinker. He has recently given his views of the present condition of things medical with especial reference to the abuse of medical charity. He says (*Western Medical Review*): "There are several remedies that might bring about a better state of things:

(1) "Medical college endowments, putting our schools above the necessity of 'doing business' with students—prospective or actual. This remedy may one day be practicable—at present, our influence upon the public does not reach the purses of the wealthy. We are not business men, and rich men do not care to turn the tide of their generosity toward medical schools.

(2) "Let reputable physicians refuse to serve on hospital staffs without remuneration. Give us a professional 'union,' if necessary, to accomplish this.

(3) "Let each physician have his own free clinic and advertise it. We all have dead-beats who had rather settle than come during our 'hours for the poor.' We all have poor patients enough to form a nucleus for a free clinic. Some may say this plan is not 'ethical.' It has been so considered by some of our most famous British physicians. What is right for a corporation is equally right for an individual doctor. Give us less ethics and more horse sense. Never mind the 'pigs in the clover.' Of course, they don't want the other fellow to break in—oh, no!

(4) "Let the general practitioner boycott every man who runs a public college clinic or serves gratuitously in public hospitals. Let him, rather, support the men who have private hospitals and clinics, and who do the profession good in a financial way, and who do not lower the respect of a selfish public for the medical profession. Let the general practitioner remember that the man who gets well-paid for the cases sent to him is the man who is the bone and sinew of the prosperity of the entire profession.

"The foregoing may seem peculiar as emanating from a college professor, but it is the more sincere."

AN IMPORTANT MATTER.

We have recently received the following letter from Doctor George M. Gould, of Philadelphia:

TO THE MEMBERS OF THE MEDICAL PROFESSION.

I would be pleased to have an expression from you, either personally or through some medical journal, as to the relations of the lay publishing firms of medical journals and the profession. The request is suggested by the fact that Messrs. Wm. Wood & Co., of New York, refuse to permit the editors of *The American Year-Book of Medicine and Surgery* to use in our abstracts of "Medical Progress" articles and illustrations first printed in the *Medical Record* and the *American Journal of Obstetrics*.

This decision seems to me to be wrong for the following reasons:

(1) **It prevents the dissemination of medical knowledge.** The *Year-Book* condenses, systematizes and criticises the year's medical work in a shorter space and more permanent manner than the journals, and has thousands of readers no single journal can claim or hope to reach. Every physician writes and publishes articles in order that every member of the profession may, if possible, learn of his work, and that science and progress may thus be furthered and humanity benefited. To interfere with such dissemination of our literature in reputable publications is, I think, discourteous and unjust to the profession and an injury to medical science.

(2) This injustice and injury to medicine become all the more striking when physicians do not receive a cent of pay for contributions, from the publication of which the lay-publisher is supposed to make considerable financial profit.

(3) No other publishers in the world, not even those who pay authors for their contributions, have in the least objected to our reproduction of quotations, abstracts and illustrations from their journals.

Do you wish to limit the dissemination of your contributions to medical science by such an exclusion of them on the part of publishers from reputable publications? **Is this literature the property of yourself and of the profession or not?** Does your gift of it to a journal make it the private property of the publishers of that journal? Is it not rather a loan for temporary use only?

Will you not hereafter demand that there be printed with your article a statement that the right of abstracting the text or reproducing illustrations is guaranteed?

Sincerely yours, GEORGE M. GOULD.

119 S. Seventeenth street, Philadelphia, Pa., December, 1896.

In our opinion, Doctor Gould is entirely right. The firm of Wm. Wood & Company is richly deserving of censure. People with common sense are pleased to have their work quoted provided due credit be given. The *Year-Book*, issued by Mr. W. B. Saunders, a progressive Philadelphian, gives credit.

If many medical gentlemen in the West refuse to subscribe for the *Medical Record* and decline to buy books published by Messrs. Wm. Wood & Company, the offending firm will probably realize that it has made another mistake.

We congratulate Mr. Saunders, the publisher of the *Year-Book*, that he has secured the services of Doctor George M. Gould, and we congratulate Doctor Gould that he has the courage of his convictions.

A SOCIETY OF SPECIALISTS.

The Western Ophthalmological, Otological, Laryngological, and Rhinological Association will meet at the Planters Hotel, St. Louis, Missouri, April 8 and 9, 1897. The address of welcome will be delivered by Dr. W. J. Langan, president of the St. Louis Medical Society, and Dr. A. C. Corr, president of the Illinois State Medical Society, will make the response. Dr. Adolf Alt, St. Louis, Mo., will take for his president's address the subject, "Hemorrhagic Glaucoma." The railroads have promised one and one-third fare. When buying tickets ask for a certificate. On reaching St. Louis have it signed by Dr. Alt.

THE MAGAZINE OF MEDICINE.

Under the able editorship of Raicy Husted Bell, of Atlanta, Ga., the *Magazine of Medicine* is gaining a permanent and honorable place in our literature. There is much in it to commend. Physicians can take it home with them with safety. If you have not seen this unique production of the Southland, send for a sample copy. It will do you good.

OUR NEXT ISSUE.

The next issue of this publication will be a very large one and will be complimentary to the Tri-State Medical Society, whose fifth annual meeting will be held in this city, April 6, 7 and 8, 1897. The *JOURNAL* will contain, among other articles, an account of the society, and this article will be illustrated elaborately. The official program will be a feature. Every reputable physician is invited to join the Tri-State family. We are getting numerous, and yet there is room for more.

THE PASSING OF CLEVELAND.

We are pleased to chronicle the fact that Grover is no more Lord of America; that American citizens will be safe from insult in Cuba and elsewhere; and that the country is rid of a President who has alienated nearly all his friends. Good-bye, Grover, and don't come back.

THE QUESTION OF THE HOUR.

As we go to press examinations are being held in the various medical colleges of this city, and many a young man is asking himself the question: "Will I graduate?" In about ten years many of these gentlemen will wonder why they ever began the study of medicine. Some few will have attained fame, but many will have dropped into other lines of work. We hope all the four hundred young men who will be graduated this year are worthy of the degree and will follow their chosen vocation with honor to the fraternity.

HISTORICAL SKETCH.

WHO DISCOVERED ANÆSTHESIA?

By JOSEPH H. HUNT, M. D., of Brooklyn, N. Y.
Chairman Historical Committee, Medical Society County of Kings.

[CONTINUED FROM THE JANUARY ISSUE.]

So far as we are concerned, surgical anæsthesia had its beginning in 1844, in a dentist's office in the city of Hartford, Conn.

I quote from a pamphlet issued during the last week, and written by one of the principal actors in this dramatic history, who is still living, a young man of 82, vivacious, cheerful, alert and still actively engaged in administering his favorite anæsthetic and looking after the great business of the Colton Dental Association, which even if he had never been personally connected with it, could have with equal propriety borne his name. I refer to Mr. G. Q. Colton, who, to quote his own story, tells us: "On the 10th of December, 1844, I gave an exhibition of laughing gas in the city of Hartford, Conn. After a brief lecture on the properties and effects of the gas, I invited a dozen or fifteen gentlemen to come upon the stage, who would like to inhale it. Among those who came forward was Dr. Horace Wells, a dentist of Hartford, and a young man by the name of Cooley. Cooley inhaled the gas; and while under its influence ran against some wooden settees on the stage and bruised his legs badly. On taking his seat next to Dr. Wells, the latter said to him: 'You must have hurt yourself.' 'No.' Then he began to feel some pain and was astonished to find his legs bloody; he said he felt no pain till the effects of the gas had passed off.

"At the close of the exhibition Dr. Wells came to me and said: 'Why cannot a man have a tooth extracted under the gas and not feel it?' I replied that I did not know. Dr. Wells then said he believed it could be done and would try it upon himself if I would bring a bag of gas to his office. The next day, 11th of December, 1844, I went to his office with a bag of gas. Dr. Wells called in a neighboring dentist, Dr. Riggs, to draw his tooth. I gave the gas to Wells, giving somewhat more than the night before, and Dr. Riggs extracted the tooth. Dr. Wells, on recovering, exclaimed: '*It is the greatest discovery ever made; I didn't feel it so much as the prick of a pin!*' That was the first tooth ever drawn without pain; a fact which no one, even Dr. Morton, ever disputed."

Mr. Colton taught Wells how to manufacture the gas and administer it and went off on his "exhibition business."

Horace Wells continued to use the nitrous oxide gas as an anæsthetic, for extracting teeth, during the remainder of that year and the following (1845), until, on account of failing health, he went to Europe the latter part of the year. We have abundant evidence that the well-known similarity in the action of nitrous oxide and sulphuric ether was discussed between Horace Wells and his friends, among whom were Dr. E. E. Marcy, who, I

believe, is still living in New York City, who prepared some ether for Wells and used some of it himself, in removing a cyst from a man's scalp. Wells also tried the ether, and pulled a tooth from a patient under its influence. He, however, found the ether unpleasant in some of its effects



Dr. Horace Wells.

(who of us has not), and also on account of its odor, and the general belief among his medical advisers that it was dangerous to life, he dropped it. Not, however, before he had communicated the fact to Valentine Mott, of New York City, and suggested that it might be used in great surgical operations. This is attested in a certificate from Dr. Mott, published in

Truman Smith's work on Anæsthesia, and also in an article in the *Boston Medical and Surgical Journal* of June 15, 1845, which is, so far as I have been able to learn, the earliest publication made on the subject.

After the use of nitrous oxide had become a familiar and well-known



Dr. W. T. G. Morton.

process in Hartford, Dr. Wells visited Boston and called on Dr. W. T. G. Morton, who had been, before removing to Boston, a student of Dr. Wells, and his friend, Dr. Charles T. Jackson, as well as Drs. Warren and Bigelow, and communicated to them what he had been doing in Hartford. Dr. Warren gave him permission to lecture before his class in the medical

college on the subject, and to exhibit his method. For some reason he failed to administer enough gas to the patient, and when the tooth was pulled the man screamed, and the students regarded the exhibition as a failure and ridiculed the unfortunate dentist and pronounced the thing a humbug. Drs. Morton and Jackson, in special, threw ridicule upon the



Dr. Gardner Q. Colton.

laudable endeavor of a sensitive young man to bring out one of the greatest discoveries of the age.

Dr. Wells, discouraged, returned to Hartford and resumed his practice. At the close of 1845 he went to Europe on account of his ill health, where he remained for several years.

It was while in Europe that he learned that his former pupil and friend were claiming as a new discovery a fact which he had himself demonstrated to them, and been successfully practicing for more than a year.

He had an opportunity while there, and presented his claims to the Academy of Sciences in Paris, and was given the honor of an M. D.

While Dr. Wells was in Europe, in October, 1846, his aforetime student, partner and friend (?) Morton, went to their mutual friend (?) Dr. Charles T. Jackson, a highly educated man, a graduated physician, a professional consulting chemist, a member of numerous scientific and other societies at home and in Europe, including the medical society which was most prominent in Boston at the time, ostensibly to borrow a rubber bag, which, he said, he wished to inflate with common air and allow a timid patient to inhale, under the impression that it would prevent the pain of having a tooth extracted. A sort of mental anæsthesia, such as was much talked of about that time in connection with so-called Mesmerism.

Accounts somewhat differ; another is that Morton called on Jackson to request him to instruct him in the method of preparing nitrous oxide gas, and found Dr. Jackson too busy with other work, which he could not give up. He took pains, however, to tell Morton that he could not make a safe gas without special instruction. That unless he had special skill he was liable to make nitric oxide, which was irritable and poisonous. Dr. Jackson suggested to him the use of sulphuric ether, telling him that its properties were very similar to the nitrous oxide, and that it could be obtained in any drug store and did not require the use of any special apparatus. He also told him that the students in a neighboring college were in the habit of using it for amusement.

Morton procured some ether and that evening, September 30, 1846, an opportunity offered itself for him to try the experiment.

Mrs. Morton, in a recent number of *McClure's Magazine*, gives a dramatic and interesting account of this, her husband's first practical application of the knowledge he had gleaned from his visit to Dr. Jackson.

It seems that a patient presented himself with his face bandaged, begging the dentist to mesmerize him while his tooth was being drawn, else he could not possibly endure the pain of the operation in his extremely sore mouth. Dr. Morton assured him that he had something better than Mesmerism, and saturated a handkerchief with the ether, which he had that day procured, and held it over the man's face while an assistant held the lamp. The operation was a complete success—even more than seemed desirable—for the subject did not at once regain consciousness after the tooth was extracted, and the frightened dentist dashed a glass of cold water in the face of the sleeping patient. This roused him and Dr. Morton inquired if he was ready to have the tooth out, and on the man's assenting, was shown the tooth lying on the floor. "Glory! Hallelujah!" was the grateful Eben Frost's (the patient's name) first exclamation, and the echo of that doxology has been heard in every operating room in the civilized world since that time.

When Morton next met his friend and preceptor (Morton had at one time been registered as a student in Dr. Jackson's office), he told him of the success of the experiment, and Dr. Jackson advised him to go to Dr. Warren (John Collins Warren), who was then the leading surgeon in Boston and professor of surgery in the medical college, and obtain his permission to administer it at the Massachusetts General Hospital, where Dr. Warren was the principal operator. An account says that "Morton

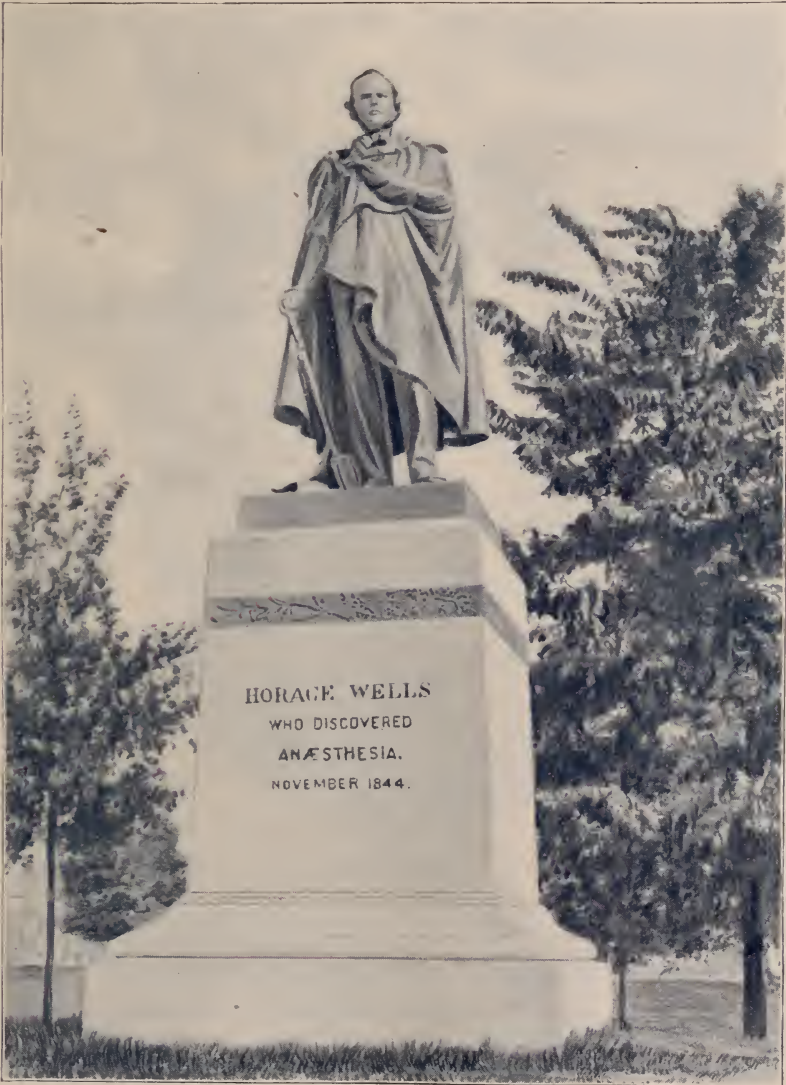
strongly objected to going to the hospital; that everybody could smell the ether and it would not be kept secret," which it seems to have been Morton's first intention to do, as Dr. Jackson says that "in the course of the conversation Morton repeatedly begged him to keep the matter secret."



Dr. Charles Thomas Jackson.

That Dr. Morton did, however, take Dr. Jackson's advice is shown by the following account given by Professor Warren, who performed the first operation on October 16, 1846: "The first proposal for the employment of ether by inhalation, for the prevention of pain in surgical operations, was made by Dr. W. G. T. Morton, about the middle of October, 1846. Calling on me he stated that he had possession of a means of accomplishing this

object; that he had made trials of its efficacy in the extraction of teeth; and that he wished me to test its power in surgical operations. The article used for this purpose not being mentioned, I supposed it was not proper for me to demand what it was; but I did think it necessary, before taking the



The Wells Monument, Hartford, Conn.

responsibility of using it or sanctioning its use, to ascertain whether a trial could be made without any apprehension of danger. Having satisfied myself on this point by various questions, I agreed to give Dr. Morton the desired opportunity as soon as it should be in my power. No such opportunity having occurred within a day or two in private practice, and being at that time in

the performance of my tour of duty at the Massachusetts General Hospital, I seized the occasion of the first operation in that institution for the proposed experiment.

“The patient was a young man about twenty years old, having a tumor on the left side of the neck, lying parallel to and just below the left portion of the lower jaw. This tumor, which had probably existed from his birth, seemed to be composed of tortuous, indurated veins, extending from the surface quite deeply under the tongue. My plan was to expose these veins by dissection sufficiently to enable me to pass a ligature around them.



Dr. John M. Riggs.

“The patient was arranged for the operation in a sitting posture, and everything made ready; but Dr. Morton did not appear until the lapse of nearly half an hour. I was about to proceed, when he entered hastily, excused the delay, which had been occasioned by his modifying the apparatus for the administration. The patient was then made to inhale a fluid from a tube connected with a glass globe. After four or five minutes he appeared to be asleep, and was thought by Dr. Morton to be in a condition for the operation. I made an incision between three and four inches long in the direction of the tumor, and, to my great surprise, without any starting, crying out or other indication of pain. The fascia were then divided, the patient still appearing wholly insensible. Then followed the insulation of the veins, during which he began to move his limbs, cry out, and utter extraordinary expressions. These phenomena led to a doubt of

the success of the application, and in truth I was not satisfied myself until I had, soon after the operation and on various other occasions, asked the question whether he suffered pain. To this he always replied in the negative; adding, however, that he knew of the operation, and compared the stroke of the knife to a that of a blunt instrument passed roughly across his neck. Now that the effects of inhalation are better understood, this is placed in the class of cases of imperfect etherization.

"On the following day an operation for the extirpation of a tumor from the arm was performed by Dr. Hayard, during which the patient exhibited no sign of physical or mental suffering." (Etherization; with Surgical Remarks. By John C. Warren, M. D., Boston, 1848. Pages 4, 5 and 6.)

It is unfortunate for the memory of Drs. Jackson and Morton that they tried to hide their discovery under the veil of secrecy and the protection of patents both in this country and in England.

I do not think that Dr. Jackson had, at first, any intention of doing so; but Dr. Morton and his attorney believed that the idea was original with Jackson, and that the fact that ether had such properties was a discovery of Dr. Jackson's, who was at that time a sort of Thomas A. Edison in chemistry and physics, and discovering all sorts of things. It seems that Morton at first had the idea of leaving Dr. Jackson out altogether, but his attorney advised him that it would not stand if both names were not associated in the application. The special peculiar odor of ether was concealed by a perfume and the material called "Compound Letheon."

Mrs. Morton, in the article from which I have already quoted, says that "he never enforced the patent for his humanity was too great to keep back from suffering millions so precious an agency of relief." That statement is partially true, but it is a fact that he abundantly tried to enforce his rights (?).

We are told that he not only sold the right to use the "Compound Letheon" in at least one city, but that he also "instituted a suit against a public charity (the New York Eye Infirmary) for having made some use in their operations of the vapor of sulphuric ether, thus violating his patent." The judge before whom the case was brought, decided against the validity of the patent, and it was carried to a higher court and the first decision confirmed. This decision of Judge Shipman of the U. S. Circuit Court, Southern District of New York, is to be found in the *American Law Register* of September, 1863.

Bearing on this subject, I quote from resolutions which were adopted by the American Medical Association at its meeting in New York in 1864:

"WHEREAS, The said Dr. Morton, by suits brought against charitable medical institutions for the infringement of an alleged patent covering all anæsthetic agents, not claiming sulphuric ether only, but the state of anæsthesia, however produced, as his invention, has by this act put himself beyond the pale of an honorable profession and of true laborers in the cause of science and humanity; therefore," etc., etc., etc. (Transactions A. M. A. 1864.)

When it was announced that the Massachusetts General Hospital, where the "Compound Letheon" had been successfully used several times, refused to use it longer unless the veil of secrecy was removed, Morton

wrote to Dr. Warren informing him that the agent used was sulphuric ether, and that they had the permission of the patentees to use it in the hospital, and asked Dr. Warren to give him a list of all similar institutions in the country, that he might extend its benefits to them.

It is singular that all four of the claimants for the discovery failed alike to publish anything in the professional journals or elsewhere, unless Morton's circular, entitled "Morton's Letheon," cautioning those who attempted to infringe upon his legal rights, a copy of which is to be found in the Library of the Surgeon-General's Office at Washington, can be called such publication. It was the reports of the operations under its influence in the Massachusetts General Hospital, that first informed the medical world what the dentists had been doing.

In this connection, I quote from an editorial in the *Chicago Medical Examiner*, December, 1865, presumably written by Dr. N. S. Davis:

"Dr. Morton's first administration of the ether in the Massachusetts General Hospital, was on the 10th [16th] of October, 1846. On the 3d of November, less than thirty days thereafter, an account of it was read by Dr. Henry J. Bigelow, to the American Academy of Arts and Sciences, and on the 9th to the Boston Society for Medical Improvement, and published by the same in the *Boston Medical and Surgical Journal* for November 18, 1846. The facts were also communicated to prominent members of the profession in London and Paris. Within six weeks it had been fully and successfully tested in London, and in three months it was in familiar use in the hospitals of Paris, from which its use spread so rapidly over the whole of Europe that in less than fifteen months Prof. Simpson had gathered and tabulated more than three hundred cases of the larger amputations alone, in which ether or chloroform had been used. The use of these anæsthetics was adopted a little less rapidly in this country than in Europe, yet, from the report already alluded to, it appears that before the 1st of April, 1848, they were in almost daily use in every public hospital in the United States, and by all the distinguished surgeons, north, south, east and west. And not only this, but they had also been administered in 'more than two thousand cases of obstetrics.' Thus, within the incredible short space of eighteen months, the use of anæsthetics had been fully introduced into the practice of surgery, obstetrics and dentistry throughout Europe and America, and that, too, without requiring Dr. Morton to travel a mile or expend a dollar beyond the limits of Boston."

[TO BE CONTINUED.]

Canadian Journal of Medicine and Surgery.—We have received the initial number of this journal, and are pleased with it. It contains 48 pages of excellent text. The editors are W. A. Young, M. D., L. R. C. P., Lond.; J. J. Cassidy, M. D., M. R. C. S., Eng., and E. Herbert Adams, M. D., all of Toronto. We wish them a prosperous and pleasant editorial voyage.

A Change.—Dr. A. D. Bevan, of Chicago, has resigned the position of chief surgeon of the Iowa Central railroad, and Dr. H. L. Getz, of Marshalltown, Ia., has been appointed in his place.

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter III.

Memories of the College for Medical Practitioners at Saint Louis, Mo.

WHY I JOINED AND LABORED SO FAITHFULLY FOR THIS POST-GRADUATE COLLEGE.

MY CIRCLE of acquaintance extending throughout the Mississippi valley, I knew there were many ambitious and deserving men desirous of obtaining more knowledge, who were unable to go to Europe and hesitated or preferred staying away from college rather than attend a course of lectures with first and second course students, and hearing the same old stories over again. Where could they go? There was no appropriate place. An institution like the above would supply the demand. Was our idea correct? What do you say to-day—every large city has its post-graduate school, and no one backward about going there from time to time to learn something new. No more sarcasm, no more laughter at the idea. The ambitious physician will obtain post-graduate what he did not get for his money as “under graduate.” I also knew that the drift of the profession was toward specialties—surgery predominant—another reason for a practitioner’s college. It is also a legitimate advertiser, countenanced by the code of ethics. Men should not “hide their light under a bushel.” In proof of what an advantage there is in college advertisement, although the school has been long a thing of the past, there is hardly a month, nay a week, passes that I do not receive mail addressed to the secretary or librarian of the College for Medical Practitioners.

We did well; in fact too well, and this may have produced superciliousness. The place was too small; they wanted a larger building, a hospital, and the Lord knows what. They were continually building air castles. We had also many among us ambitious for a surgical chair, for surgery tells. There were any number of little unpleasanties continually arising.

After the last session, March, 1884, we had a faculty meeting; I do not recall all who were present; many changes were proposed; plans for a new hospital and college were discussed; one suggested this, another that, and a third something entirely different; they finally came to one decision—as to the construction of the building. Some fancied the building completed; they could see it in their mind’s eye: how symmetrical and pleasing it looked from the outside, and what magnificence upon entering; imagine standing in the amphitheater, lecturing to a large class of admiring practitioners, demonstrating the use of the vaseline spray or vaginal douche—would not that be nice? But, alas, for their dreams—where was the ground upon which to build? They all agreed that this was to be a large square, *surrounded by a fence*; now, it was this very fence that nipped their plans in the bud, for they were at sixes and sevens as to whether it should be of

iron or wood, painted red, white or black, with gold or silver ornamentations, and the greatest trouble was how to obtain this bronze for a finish. (They were all pregnant with air castles, but the bubbles burst before born, and abortion took place.)

I listened to all their eloquent and convincing arguments in silence, filled with amazement. At last the faculty desired my opinion, and here it is: "Mr. President (Dean), and Gentlemen: If I had you all in my stomach, I would take an emetic and vomit you into the Mississippi river. Here is my resignation!" This proved a bomb. Where uproar had prevailed, silence now reigned. In a few moments I was gently informed that "they could run the college without me." As I retired from the field of action I wished them God-speed, at the same time predicting there would not be another session.

Later, I took a trip to Europe by way of recreation, and when I returned, the college for medical practitioners was no more. (The fence did it.)

HOW TO OBTAIN A GOOD CLINIC AND LARGE AUDIENCE, AND HOW
I WENT ABOUT IT.

First of all, it requires system, patience and punctuality. I treated my poor patients with attention and courtesy such as I bestowed upon those who could well afford to pay; I would present and select cases of my private practice at my clinical lectures that were adapted to the subject upon which I was to speak. I was never absent from my clinic, and never missed a single lecture during any of the sessions. I preferred losing the best paying case, rather than disappoint the students (which also saved me the trouble of "making excuses"). I was on hand to the minute, two o'clock, and my hearers were generally on time. I never allowed myself to say an unkind word, or throw out any insinuation about any other practitioner or teacher of this or any other college. I attended strictly to my obligations. I treated those who attended my clinical lectures as fellow-practitioners, as if they were men of thought and experience and not first course students. In addition to the college announcement, I would mail to the profession elegant cards (private expense), inviting them to my clinics, stating for the whole session the days, dates and subjects of my lectures, viz.: Inflammatory processes of wrist, elbow and shoulder, Thursday, November 8, 1883; injuries of the skull and brain, Tuesday, November 13, 1883, and so on. This I repeated every session, and by this process I had an addition to my regular class, and in time physicians from the country would come in, upon certain days, to hear one or the other of my lectures, upon subjects in which they were most interested. I gained a reputation for punctuality, and those who came from a distance knew they would not make the trip for nothing. Again, if I had material of an unusually interesting nature, I sent postals out to my friends, inviting them to be present upon a certain date; at first they came sparingly, but gradually the number increased, and my lecture-room was always filled, frequently crowded. The older members of the profession, of the city, would occasionally honor me by being present, as well as students from other colleges. It is slow and tedious work, but it pays, although it creates envy. My colleagues could not comprehend why my clinics were such a success. I informed them: "It is produced by the effect of my *foreign accent*."

CONCLUSION.

In my opinion, St. Louis is at present a splendid field for a Post-Graduate Polyclinic College for Medical Practitioners, provided the right kind of men undertake the management of such a school.

My idea is this: The teachers should be specialists in their respective branches, having years of practical experience, with at least a good local reputation, and more, if possible. They should teach for the sake of teaching, and not for the remuneration it may afford, taking a pride in instructing those who come to them for information; they should not teach simply for the purpose of displaying their own skill and impressing their hearers with the idea what great fellows they are.

Men who have practiced for ten years, more or less, cannot afford to waste their time and money on lectures read from manuscripts (which may have been copied from a text-book) by some would-be teacher.

Practical clinical instruction is what is wanted by the practitioner who attends a post-graduate course. He should do the work himself, under the guidance of his teacher, so that when required of him he feels capable of undertaking such an operation. His teacher should evince an interest in him. This will tend to increase the reputation of the specialist, and will also be a profit, having taught his pupils well, instead of impressing his own imaginary greatness upon them; telling them that "such and such an operation should not be performed except by an expert"—of course, the said specialist is always the only expert in the city. The specialist teacher should not believe every one but himself a fool.

I said "the teachers should be specialists." Not that they should endeavor to make a specialist of every one who attends their clinical instructions, but imparting that knowledge to the practitioner which may be required in his general practice, paying special attention to the country doctor.

Now, a college like this could be started with little difficulty; we have plenty of competent material in St. Louis. A few specialties would do; for a beginning, say the eye, ear, nose, throat, skin diseases, genito-urinary tract, diseases of the stomach, surgery, diseases of children, or gynæcology. (Other chairs could be added in time.) It would be well to have the instructions in *one* building, or if that were impracticable, in different places; offices or hospitals. There could not be a certain amount specified for a full course, as it would be impossible for one to attend six or eight instructions in one day, and continue for a month or more. It would be sufficient to attend one or two at a time, in order to be thorough; each professor's ticket costing \$25.00 or \$30.00 (or whatever might be decided) per month.

A class should consist of not more than ten students at a time; then there could be no jealousy among the professors. Each one works for himself, and all for a common cause.

If no college can be opened at present, I do not see why some of our able specialists do not give private instruction or lecture to classes, at intervals. It would pay; I know from practical experience, extending over a period of eight years. Of this I will treat more minutely in another chapter.

TRI-STATE MEDICAL SOCIETY OF IOWA, ILLINOIS AND MISSOURI.

The Society will meet in Saint Louis, April 6, 7 and 8, 1897.

PRELIMINARY PROGRAM.

Dr. Joseph Price, of Philadelphia, will conduct the Surgical Clinic.
Dr. Jas. T. Whittaker, of Cincinnati, will conduct the Medical Clinic.
Dr. Dudley Reynolds, of Louisville, will conduct the Ophthalmic Clinic.
Prof. Edwin Klebs, of Chicago, will give a Pathological Demonstration.
Dr. J. Mount Bleyer, of New York, will demonstrate the use of the
Fluoroscope in Diseases of the Lungs.

Dr. Fenton B. Turck, of Chicago, will read a paper on "Olyocythæmia
and Leucocytosis in Gastro-Intestinal Diseases, with Methods of Treatment."
Demonstrations.

Dr. G. Frank Lydston will entertain the Society on the evening of the
7th with "An Original Doctor's Story, and Plenty of Points."

The following papers will be read:

Dr. Thos. H. Manley, of New York, "The Morbid Anatomy of In-
flammatory and Degenerative Diseases of the Peripheral Veins";

Dr. J. K. Bauduy, St. Louis, "Unconscious Cerebration";

Dr. W. F. Waugh, Chicago, "Some Phases of Narcomania";

Dr. Charles W. Purdy, Chicago, "The Management of Chronic
Bright's Disease";

Dr. Robt. O. Cross, Kansas City, "The Treatment of Pulmonary
Tuberculosis by the Hypodermic Method";

Dr. G. M. Phillips, St. Louis, "Physiological Copulation";

Dr. G. F. Hulbert, St. Louis, "The Treatment of the Stump in
Hysterectomy and Hystero-myomectomy";

Dr. Ohmann-Dumesnil, St. Louis, subject not announced;

Dr. J. W. Fowler, Dubuque, "The Cause and Treatment of Epilepsy";

Dr. Carl Theodor Gramm, Chicago, "The Mouths of our School-
Children";

Dr. F. Reder, Hannibal, "Lumbago";

Dr. W. Scheppegrell, New Orleans, "The Collapse of the Nasal Alæ
as an Etiological Factor in Diseases of the Respiratory Passages";

Dr. Allen Staples, Dubuque, "Some Clinical Notes on Vaginismus";

Dr. O. Beverly Campbell, St. Joseph, "A Plea for the Early Recognition
and Operative Treatment of Cancer of the Uterus";

Dr. J. M. Black, Knoxville, Tenn., "Surgery of the Gall-Bladder"
(with report of cases);

Dr. C. E. Ruth, Keokuk, Iowa, "Talipes—Equino-Varus, Surgery of";

Dr. J. R. Pennington, Chicago, "The Necessity for a More Careful
Examination of the Rectum in Chronic Diseases";

Dr. David Liebiethal, Chicago, "About the Treatment of Skin
Diseases";

Dr. J. O. DeCourcy, St. Libory, Ill., "Malaria";

Dr. D. C. Brockman, Ottumwa, Iowa, "Pancreatic Cysts";

Dr. E. J. Senn, Chicago, "Gonorrhœal Synovitis";

- Dr. Jno. Punton, Kansas City, "The Relation of the Science of Medicine to Public School Education";
- Dr. S. S. Davis, Fulton, Mo., "La Grippe and Its Sequelæ";
- Dr. H. C. Dalton, St. Louis, "A Case of Strangulated Inguinal Hernia—Resection of Intestine—Recovery";
- Dr. H. H. Vinke, St. Charles, Mo., "Presentation of a Cretin—Remarks on Treatment with Thyroid Extract";
- Dr. A. C. Klebs, Citronville, Ala., "The Necessity of Special Institutions for the Treatment of Pulmonary Tuberculosis";
- Dr. H. C. Finch, Lynnville, Ia., "Convulsions Following Labor" (remote);
- Dr. J. M. Allen, Liberty, Mo., "Serum Therapy, with Report of Cases";
- Dr. Donald Macrae, Jr., Council Bluffs, Ia., "Report of a Case of Echinococcus of the Liver with Rupture of Gall-Bladder";
- Dr. G. Wiley Broome, St. Louis, "The Pathology of Malignant Disease";
- Dr. J. A. Close, St. Louis, subject not announced.
- Dr. E. H. McCullers, St. Louis, subject not announced.
- Dr. Emory Lanphear, St. Louis, "Treatment of Septicæmia by Subcutaneous Medication";
- Dr. Wellington Adams, St. Louis, "A New and Practical Method of Opening and Dilating the Eustachian Tube";
- Dr. S. G. Gant, Kansas City, subject not announced.
- Dr. J. Block, Kansas City, subject not announced.



Pye's Surgical Handicraft. A Manual of Surgical Manipulations, Minor Surgery and Other Matters Connected with the Work of House Surgeons and Surgical Dressers, with 300 Illustrations on Wood. First American from the third London edition. Revised and Edited by T. H. R. CROWLE, F. R. C. S., Surgical Registrar to St. Mary's Hospital, and Surgical Tutor and Joint Lecturer on Practical Surgery in the medical schools. Two volumes. New York: E. B. Treat, 5 Cooper Union; 1893.

This work of Mr. Pye is an especially well designed ready-reference work for the busy house surgeon, surgical dresser, practitioner or student. It deals with many small things which are so often omitted in larger works, and which are so often of great value. It is profusely illustrated, and the prominent marginal catchwords are a very useful feature. The special chapter on the administration of anæsthetics is worth the price of the book.

American Year-Book of Medicine and Surgery. By Eminent American Specialists and Teachers, under the General Editorial Charge of GEORGE M. GOULD, M. D. One volume of nearly 1200 pages, profusely illustrated. Prices: Cloth, \$6.50 net; Half-Morocco, \$7.50 net. Philadelphia: W. B. Saunders, 925 Walnut street; 1897.

The American Year-Book has become a necessity to every physician who wishes to know the recent advancements in our progressive profession. It is a whole library in one volume. It is no mere compilation, for each section has been entrusted to an experienced and able contributor, and the reader is thereby assured of critical commentaries of the utmost value. The Year-Book should be found in every medical library.

A System of Practical Medicine. By American authors. Edited by ALFRED LEE LOOMIS, M. D., late Professor of Pathology and Practical Medicine in the New York University, and WILLIAM GILMAN THOMPSON, M. D., Professor of Materia Medica, Therapeutics and Clinical Medicine in the New York University. To be completed in four imperial octavo volumes, containing from 900 to 1000 pages each, fully illustrated in colors and in black. Vol. I., Infectious Diseases; just ready. Vol. II., Diseases of the Respiratory and Circulatory Systems, and of the Blood and Kidneys; in press. Vol. III., Diseases of the Digestive System, of the Liver, Spleen, Pancreas and Other Glands, Gout, Rheumatism, Diabetes and other Constitutional Diseases; in active preparation. Vol. IV., Diseases of the Nervous System and of the Muscles, Diseases of Doubtful Origin, Insolation, Addison's Disease, etc.; in active preparation. Per volume: Cloth, \$5.00; Leather, \$6.00; Half Morocco, \$7.00. Lea Brothers & Co., publishers, Philadelphia and New York.

The design of the American System of Medicine presents a thoroughly practical work of ready reference for the practitioner of general medicine. Extended historical references and discussions of mooted theories have been omitted, but each author has sought to present the results of his personal experience and combine them with the views of other acknowledged authorities. In conformity with the practical character of the system it contains no general articles upon hygiene, bacteriology, pathology or symptomatology, but these subjects are separately presented in connection with each disease, thus facilitating reference by making each article a complete practical treatise in itself. Much original research and investigation have been undertaken by the authors expressly for this work, the results of which the reader will find both in the text and in the illustrations. The latter have been made a special feature of those articles which admit of such elucidation. Minute details are given in each practical subject, as examination of the blood in malaria and in anæmia, the examination of the sputa, physical diagnosis of the chest, the localization of disease of the brain, spinal cord, etc. Particular attention has everywhere been bestowed on full directions for treatment, while original prescriptions, formulæ, diagrams, charts and tables have been inserted wherever their admission seemed desirable. Much care has been devoted to the preparation of the indexes, as upon their completeness depend very greatly the convenience and utility of the system.

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The American System of Medicine is, therefore, a work of which every American physician may reasonably feel proud, in which every practitioner will find a safe and trustworthy counsellor in the daily responsibilities of practice, and for which the publishers may justly and confidently anticipate a circulation unexampled in the annals of medical literature.

Ophthalmic Operations as Practiced on Animals' Eyes. By CLARENCE A. VEASEY, A. M., M. D., Adjunct Professor of Diseases of the Eye, Philadelphia Polyclinic. Duodecimo, pp. 99, with 56 Illustrations. Philadelphia: The Edwards & Docker Co.; 1896.

Doctor Veasey is to be congratulated upon producing a book for which there is a demand. The volume will prove of assistance to those beginning the study of ophthalmology by enabling them to become familiar with the technique of the various ophthalmic operations through practice on animals' eyes.

MEDICAL PROGRESS.

The New Local Anæsthetic.—As eucaïne hydrochlorate is destined to supplant cocaine in many cases where the latter has hitherto been used as a local anæsthetic, we have thought it desirable to review briefly some points of practical interest in regard to the new agent.

Advantages of Eucaïne.—Despite the improvements in the technique of cocaine anæsthesia, cases of more or less serious poisonous effects from this drug are still commonly encountered, and tend to restrict its field of utility. The fact, therefore, that eucaïne is practically innocuous in the amounts ordinarily required to produce anæsthesia, is itself an important advantage. Dr. G. W. Spencer, of Philadelphia (*Univ. Med. Magaz.*, November, '96), who has had considerable experience with eucaïne, states that it has proved harmless in amounts as large as twelve and fifteen grains. This author further says that this agent produces the most complete local anæsthesia of any drug he has ever tried, and according to the observations of other investigators, the anæsthesia produced by eucaïne is at least equal in rapidity, intensity and duration to that of cocaine. As a local anæsthetic in ophthalmic practice, eucaïne will also be frequently found preferable to cocaine because its use is unattended with mydriasis or corneal troubles, although the slight ischæmia sometimes observed may occasionally be an objectionable feature. Among the minor advantages of eucaïne are that its solutions are much more stable than those of cocaine, are undecomposed by prolonged boiling and can therefore be sterilized.

In view of the already extensive literature on eucaïne, we will confine ourselves to pointing out the chief clinical uses of this new agent.

Ophthalmology.—Vinci and Berger, who were the first to employ eucaïne in diseases of the eye and various operative procedures upon that organ, both consider it an anæsthetic of great value, and regard the absence of mydriasis and corneal dryness as of very great clinical importance. R. B. Carter (*Lancet*, July 11, '96) also considers the fact that eucaïne does not affect the pupil as an advantage of practical value in various operations upon the eye, as illustrated in a case of cataract extraction in his practice. Professor H. Cohn, of Breslau, for the same reason prefers it to cocaine in glaucoma and strabismus operations. Dr. J. C. Clemesha (*Buffalo Med. and Surg. Jour.*) has employed it with success in cases of removal of foreign bodies in the cornea, and states that Dr. Howe has obtained equally successful results from its use in extractions and iredections.

Minor Surgery.—In his first article, already referred to, Dr. G. W. Spencer reported a series of twenty operations for ingrowing toe-nails, abscesses, ulcers, small tumors, in which eucaïne produced rapid, complete and prolonged anæsthesia without systemic effects. In a later report (*Med. and Surg. Rep.*, November 28, '96) of twenty-four cases occurring in his own practice and that of Professors Keen and Brinton and Drs. Hearn, DaCosta and Horwitz, eucaïne anæsthesia was utilized in a large number of instances in which systemic

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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| DR. THOMAS MORE MADDEN, Dublin, Ireland. | DR. JOHN I. SKELLY, Pekin, Ill. |
| DR. A. H. CORDIER, Kansas City. | DR. DAVID CERNA, Galveston, Texas. |
| DR. JOHN PUNTON, Kansas City. | DR. E. J. BROWN, Decatur, Ill. |
| DR. WM. JEPSON, Sioux City, Iowa. | MR. CLARK BELL, New York. |
| DR. H. SNELLEN, JR., Utrecht, Holland. | DR. F. I. HAYNES, Los Angeles, Cal. |
| DR. W. B. OUTTEN, St. Louis. | DR. JAMES A. CLOSE, St. Louis. |
| DR. C. LESTER HALL, Kansas City. | DR. PINCKNEY FRENCH, St. Louis. |
| DR. ARTHUR E. MINK, St. Louis. | DR. F. REDER, Hannibal, Mo. |

Vol. IV.

ST. LOUIS, MO., MARCH, 1897.

No. 3.

ORIGINAL ARTICLES.

HISTORY OF THE TRI-STATE MEDICAL SOCIETY OF IOWA, ILLINOIS AND MISSOURI, WITH SKETCHES OF SOME OF THE MEMBERS.

BY AN OLD MEMBER.

AMONG the many medical societies of this country which have gained the attention of the profession, there is probably not another whose growth has been so rapid as that of the Tri-State Medical Society of Iowa, Illinois and Missouri. Its years are indeed few, but the results accomplished are such as would do honor to the oldest medical organizations of the land. The success of the Tri-State is a brilliant example of what young blood, new ideas and perseverance can accomplish in this hustling, bustling and progressive mid-continent region. The territory through which flows that grand river known as the Mississippi will some day be the seat of medical empire of the western world. Already Chicago can boast of Senn's clinic, which is acknowledged to be surpassed by none on earth. Already the excellence of the medical schools of this mid-continent territory is such that it is no longer necessary to travel east in search of medical light. What a quarter of a century may bring forth, no man can tell; but surely he would be a modest prophet who would hesitate to claim that within a few years the best medical schools, the finest hospitals, and

the best teaching* in all America will be found in this same Mississippi Valley.

It was in the beautiful city of Keokuk, Iowa—town of the Indian chieftain's name—that the Tri-State was born.

It was on November 13, 1891, that a call was issued for a meeting of physicians, to be held in Keokuk, for the purpose of forming a society whose membership should be "composed of regular physicians residing in South-eastern Iowa, Northeastern Missouri, and the adjacent part of Illinois." In accordance with this call, a large number of physicians assembled in



Dr. Robert H. Babcock, of Chicago, Ex-President of the Tri-State Medical Society.

the Estes Hall, in the city of Keokuk, on November 24, 1891. A temporary organization was effected by the selection of Dr. J. R. Hollowbush, then of Warsaw, Ill., now of Rock Island, as President *pro tempore*; and Dr. W. H. Newlon, of Ft. Madison, Iowa, as Secretary *pro tempore*. A committee of three—Drs. James Moores Ball and J. C. Armentrout, of Keokuk, and Dr. J. R. Hull, of Sciota, Ill.—was appointed to prepare a constitution and by-laws. Dr. R. H. Fegers, of Keokuk, then read a paper, "My Views on Eczema." Dr. C. E. Ruth, of Muscatine, Iowa, read a paper entitled, "Laparotomy for Appendicitis." The present con-

stitution and by-laws were adopted. The constitution was signed by the following: W. H. Newlon, W. T. Eckley, F. C. Roberts, Geo. P. Neal and J. M. Casey, Jr., of Ft. Madison, Iowa; J. A. Scroggs, S. W. Moorehead, J. M. Shaffer, R. M. Lapsley, Geo. F. Jenkins, R. H. Fegers, W. V. English, James Moores Ball, D. J. Payne and J. C. Armentrout, of Keokuk, Iowa; T. G. McClure, Douds, Iowa; C. E. Ruth, Muscatine, Iowa; Wm. W. Nelson, Birmingham, Iowa; T. C. Hays, Vincennes, Iowa; A. D. Leech, Farmington, Iowa; H. S. Reese, Wayland, Mo.; J. R. Hollowbush, Warsaw, Ill.; J. E. Parrish, Memphis, Mo.; J. R. Hull, Sciota, Ill.

The following officers were then elected: President, Dr. J. L. Hull, of Sciota, Ill.; Senior Vice-President, Dr. T. G. McClure, of Douds, Iowa;



Dr. O. Sutter, St. Louis, Mo.



Dr. Webb J. Kelly, Galion, Ohio.

Junior Vice-President, Dr. J. M. Casey, Jr., of Ft. Madison, Iowa; Secretary, Dr. James Moores Ball, of Keokuk, Iowa; Treasurer, Dr. H. S. Reese, of Wayland, Mo.

A paper was then read by Dr. Ball upon "An Improved Method of Inflating the Middle Ear." On motion, the Society adjourned to meet in Keokuk on the first Tuesday of March, 1892.

FIRST REGULAR MEETING.

This was held in Keokuk, the 1st of March, 1893. It was proposed to amend the constitution so that Article IV. should read as follows: "The regular meetings of this Society shall be held on the first Tuesday of April and October, at such place as shall be decided by vote of the

Society." Papers were read by Drs. W. R. Allison, of Good Hope, Ill.; W. V. English, of Keokuk; W. B. Sisson, of Kahoka, Mo., and Dr. W. H. Martin, of the same city. The new members joining at this meeting were Drs. W. I. Bogle, of Keosauqua, Iowa; J. J. Rigg, Keokuk; J. H. Coulter, Summitville, Iowa; T. J. Maxwell, Keokuk; W. H. Martin, W. B. Sisson and B. S. Crawford, of Kahoka, Mo.; W. R. Allison, Good Hope, Ill.; O. F. Pile and H. M. Stone, Memphis, Mo., and J. H. Beucler, Athens, Mo.



Dr. C. Lester Hall, Kansas City, Mo.

FIRST ANNUAL MEETING.

This was held in Kahoka, Mo., October 4, 1892. In the absence of the President, Dr. J. M. Shaffer, of Keokuk, presided. The new members were Drs. Calvin Snook, of Fairfield, Iowa; J. G. Hainline, Keokuk; H. C. Young, Fairfield, Iowa; B. H. Edelin, Gorin, Mo.; George King, Hitt, Mo.; W. E. H. Bondurant, Downing, Mo., and C. J. Hagan, Alexandria, Mo. The proposed amendment to the constitution was adopted. Papers were read by Drs. Beucler, Shaffer, Coulter, Pile, Hays and Snook. Officers were elected as follows: President, Dr. W. H. Martin, of Kahoka,

Mo.; Senior Vice-President, Dr. Calvin Snook, of Fairfield, Iowa; Junior Vice-President, Dr. O. F. Pile, of Memphis, Mo.; Treasurer, Dr. H. S. Reese, of Wayland, Mo.; Secretary, Dr. James Moores Ball, of Keokuk, Iowa.

THIRD SEMI-ANNUAL MEETING.

This was held in Keokuk, April 4 and 5, 1893. In the absence of the President, Dr. George F. Jenkins was called to the chair. The list of new members was as follows: H. R. Wittwer and J. B. Murphy, of Chicago;

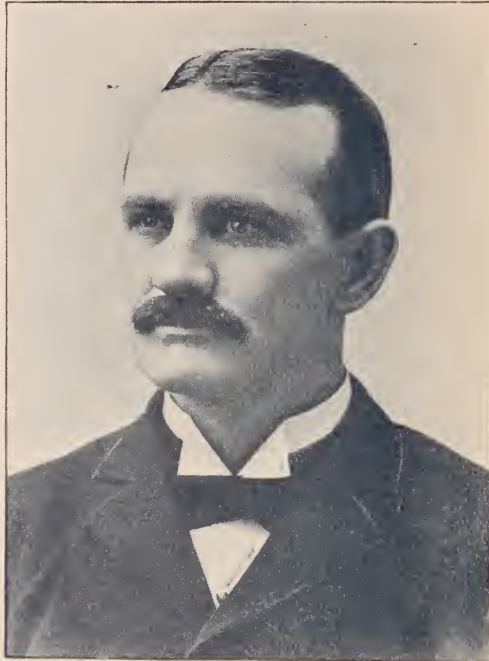


Dr. Eugene Smith, Detroit, Michigan.

B. S. Pennington, Kossuth, Iowa; Emory Lanphear, Kansas City, Mo.; W. B. Maddox, Montrose, Iowa; H. B. Young, Burlington, Iowa; J. A. Shreck, Cameron, Ill.; S. K. Davis, Libertyville, Iowa; Woods Hutchinson, Des Moines, Iowa; F. J. Graber, Stockport, Iowa; J. B. Bridges, Downing, Mo.; Roger N. Cresap, Bonaparte, Iowa; Frank P. Norbury, Jacksonville, Ill.; J. Fred Clarke, Fairfield, Iowa; E. O. Sisson, Keokuk, Iowa; W. L. Downing, Moulton, Iowa; W. W. Holmes, Keokuk, Iowa; R. Wagner, Memphis, Mo.; Miss May B. Stuckey, Galesburg, Ill.; W. H.

Dewey, Merville, Iowa; John A. Prince, Springfield, Ill.; J. F. Percy, Galesburg, Ill.; F. Reder, Hannibal, Mo., and Louis Becker, Knoxville, Illinois.

Papers of the greatest value were read at this meeting. Among the best were the following: "A New and Improved Method of Removing the Uterus," by Emory Lanphear; "Impetigo Contagiosa," by Louis Becker; "The Rubber Bulb as an Aid in Intestinal Surgery," by F. Reder; "Prostitution; Its Cause, and the Relation of the Medical Profession to Its Abolishment," by J. F. Percy. Two important lectures were given: one on "Intestinal and Other Anastomoses," by J. B. Murphy, of Chicago; the other on "The Importance of Beauty as a Therapeutic Aim," by Woods



Dr. Wishard, Indianapolis, Indiana.

Hutchinson, now of Buffalo, N. Y., who at that time resided in Des Moines. The evening of April 5th a banquet was held at the Hotel Keokuk. The reading of papers was continued the next day.

SECOND ANNUAL MEETING.

This was held in Peoria, Ill., October 3 and 4, 1893. Owing to dissensions in the local profession, our reception was far from satisfactory; but thanks to the splendid efforts of Drs. O. B. Will, M. S. Marcy, W. R. Allison, Ezra Weis, and others, our stay was made pleasant. From a scientific standpoint, the meeting was a great success. A fine lecture upon "The Wonders of the Brain" was delivered by Dr. Lanphear; Dr. A. E.

Prince, of Jacksonville, Ill., read a paper on "Corneal Nutrition and Repair;" Dr. J. S. Pyle, of Canton, Ohio, made "A Plea for the Appropriation of Criminals to the Experimental Physiologist;" Dr. Marcy read a valuable paper on "Abortion;" Dr. E. Wyllys Andrews, of Chicago, read a paper entitled "Recent Improvements in the Surgery of Hernia;" Dr. Bayard Holmes, of the same city, addressed the Society upon some important sociological questions; Dr. A. V. L. Brokaw, of St. Louis, read a paper on "Conservative Treatment of Uterine Myomas;" Dr. John Punton, of Kansas City, discoursed on "Treatment and Prophylaxis of Insanity;" Dr. George Minges, of Dubuque, Iowa, read a paper on "Further Experience with Koch's Tuberculine;" and Dr. E. J. Blair, of Monmouth, Ill., described a case of "Amputation Above the Hip-Joint." Following is the



Dr. Frank J. Lydsto, Chicago, Illinois.

list of new members: L. R. Ryan, Galesburg, Ill.; C. S. Chase, Waterloo, Iowa; A. T. Barnes, Bloomington, Ill.; A. V. L. Brokaw, St. Louis; E. Wyllys Andrews, Chicago; Boerne Bettman, Chicago; D. C. Brockman, Ottumwa, Iowa; E. H. Butterfield, Ottawa, Ill.; Arthur Parsons, Elmira, Ill.; A. E. Prince, Springfield, Ill.; Everett J. Brown, Decatur, Ill.; John Punton, Kansas City; George Minges, Dubuque; J. A. Plumer, Trivoli, Ill.; E. J. Blair, Monmouth, Ill.; Ezra Weis, M. S. Marcy and O. B. Will, Peoria. Officers were elected as follows: President, Dr. D. C. Brockman, of Ottumwa, Iowa; Senior Vice-President, Dr. Emory Lanphear, of Kansas City; Junior Vice-President, Dr. W. R. Allison, of Peoria, Ill.; Treasurer, Dr. C. S. Chase, of Waterloo, Iowa. Dr. Ball was re-elected Secretary.

[TO BE CONTINUED IN OUR NEXT ISSUE.]

LEPROSY.*

By A. H. OHMANN-DUMESNIL,

Professor of Dermatology and Syphilology in the Marion-Sims College of Medicine,
St. Louis.

THERE is perhaps no disease which has been more spoken of with less knowledge on the part of the general public, and of a great proportion of the medical profession, than leprosy. Nor is there one which has been so much subjected to misinterpretation or which has produced so much fear and terror in the popular mind. The latter is no doubt due to the Biblical influence induced by unconscious misinterpretation on the part of translators and commentators. For, it is a well-known fact that in many oriental countries but little attention is paid or importance attached to lepers, they intermarrying with the healthy, coming in daily personal contact with the unaffected, and being treated without any difference from others not leprosy. It may possibly be that the writer of the book of Leviticus had but a restricted knowledge of the disease itself, as we find psoriasis called leprosy—and in comparatively modern times, *lepra alphas*. Aaron himself had leprosy (psoriasis) and was admitted within the Holy of Holies, an act which would not have been permitted had he been suffering from true *lepra*. On the other hand, the Jew who had leprosy was declared "unclean" and pronounced a pariah. From this arose the popular idea that the disease was contagious; and, it may be stated as a matter of fact, that the Semitic race in the Orient presents more leprosy subjects than any other, so far as they have been observed in Palestine, Syria, Turkey, the Mediterranean Islands and in that neighborhood.

To-day the disease may be said to practically exist all over the world, the smallest numbers being found in Europe and in the United States. India is estimated to harbor over 300,000 lepers. China is also known to contain large numbers. The countries mentioned above continue to furnish their quota. The Sandwich Islands are notorious for the number of lepers found there. Mexico and the South American countries also present many cases of the disease, and the list might be continued almost indefinitely.

The burning question connected with leprosy is whether it is a contagious malady or not. As we have already stated, the Ancient Hebrews regarded it as such, and this opinion was intensified in Europe during the Middle Ages, but more especially after the first return of the Crusaders from the Holy Land. Such a large number returned afflicted with "leprosy" and transmitted their disease that it was not long before severe means were adopted to prevent its spread. The dissemination of the trouble finally became so great that the unfortunate victims were kept incarcerated in special buildings; and it is estimated that at one time there existed no less than *thirty thousand* leper houses in Europe. A critical examination of the accounts and descriptions of the disease, as it then occurred, will demonstrate to an impartial reader that the trouble was in reality syphilis. This readily explains its rapid dissemination and its ready contagion. Treatment being ignorantly applied, the patients neglected and abhorred, also

* * Read before the St. Louis Academy of Medical and Surgical Sciences.

easily explains the ravages which it made and the rapid deaths which followed in its wake. Those not syphilitic suffered, in a certain proportion, from the bubonic plague, and a very few were probably leprosy.

On the other hand, we have the curious history of the spread of the disease in the Sandwich Islands. It is not so many years ago that leprosy



FIG. 1. Tubercular Leprosy, (Mexican Woman.)

was unknown in the islands. A Chinaman affected with leprosy, so the account goes, was the original focus, and from him it spread to the natives, and from one to the other with such frightful rapidity that it might be said with propriety that these islands are naught but one vast leper colony. Father Damien, the Belgian priest who lived among them for years, finally

contracted leprosy and succumbed to the disease. In the case of the Sandwich Islands there is no doubt of the certainty that the disease is leprosy, and it would seem, at first glance, to be an irrefutable argument in favor of the contagiousness of the disease. Careful study and inoculations by competent investigators have failed to show that leprosy is contagious, but it is inoculable with the greatest difficulty and only under special circumstances. Pure cultures of the lepra bacillus have failed to bring on the trouble, and perhaps the only method which has been found to be successful in transmitting the disease is by vaccination from the visicle of a leper. This is certain to transmit the disease in nearly every case. The entire question still remains *sub judice*; and in many experimental cases nothing definite can be stated, as the disease is one having a long period of incubation, being itself a very chronic process, patients with the disease living as long as sixty or seventy years after its first manifestation declares itself.



FIG. 2. Tubercular Leprosy. (Chinaman.)

No attempt will be made to give a complete description of the disease, as a mere outline would fill a volume. A description of one or two typical cases may, perhaps, give a faint idea of the more prominent characteristics of the trouble. One of the commoner forms is the tubercular. Good pictures of this form are given in Figures 1 and 2. Figure 1 is a picture of a Mexican woman, spinster, about 53 years of age, who applied to me for treatment. She was employed as a nurse in a family of Mexicans, taking care of an infant and a small girl, neither of whom contracted the disease, and whose parents laughed at the suggestion of such a possibility. The patient stated that she had had the disease for years, and had never suffered any particular discomfort from it, with one possible exception. This was a complete anæsthesia of the integument of the limbs and of the face and head. She could not feel the prick of a needle, nor was she aware of the fact when a piece of her skin was excised. This symptom, which

is quite the most prominent one in the anæsthetic form of leprosy, is one observed in more than eighty per cent of the cases of the disease which are examined in reference to this special symptom. It is a particularly important point to establish, from the fact that it is far from rare to observe mutilating ulcerations of the fingers and toes follow it. Although these heal spontaneously, they leave mutilations which are, in many instances, hideous, and only less so than the deformity of the nose occasioned by the necrosis and caries of the bones, and ulceration of the soft lining structures.

As in all cases of leprosy of the tubercular and anæsthetic forms, there existed in this case the peculiar velvety feel of the skin. It also had the doughy consistence so characteristic of the condition; the tubercles were also softish to the touch, and there was present a great looseness of the integument. This was most marked on the arms, the skin hanging from the upper portions of the arms like the dewlap from a bull's neck. Since observing it in this case, I have noted its presence in every leper I have had occasion to observe; and, whilst it is not particularly mentioned by leprologists, it would certainly be instructive to learn whether it is a constant symptom or not. To resume the description of the case: On the dorsal aspects of the hands and feet, as also upon the fore-arms and legs, large, soft tubercles, darker in color than the surrounding skin, presented themselves. The face (as may be seen from Figure 1) was a typical one, and gave the characteristic leonine expression of tubercular leprosy. The tubercles were disseminated over the entire countenance, the nose having the characteristic broadening, the superciliary eminences accentuated, the lips thickened, and the cheeks hanging down in flabby folds. Along the edges of the nares small split-pea sized tubercles were present, and these were excised without producing any pain. As is the case in all operations on lepers, be they trivial or serious ones, healing occurred very rapidly and without extensive scars. The ears were large, soft and velvety, being thickened to quite a considerable degree. So far as the general condition of the patient was concerned, all the functions seemed to be properly performed, menstruation being still present and regular. The patient's appetite was fair, and sleep good. No particular pains were complained of, and the woman seemed to be always in a cheerful and contented mood. She was not irritable, and was unusually patient with her charges.

This case is not so well marked as the one shown in Figure 2. Here we are presented with one occurring in a Chinaman. In this case the tubercles are much more marked, and the folds are thick and furrows deep. The neck is traversed by folds, and the expression of the face has a fierceness lent to it not due to any disposition of the kind. The Chinese always present a more hideous appearance than any other race. This is no doubt due to the peculiar conformation of the features in the Mongolian.

The anæsthetic form of leprosy is not frequently met in its pure form. In fact, nearly all forms are mixed. In the anæsthetic, the macular form is seen; the anæsthetic is mixed with the tubercular, etc. One peculiar phase of the anæsthetic form which has elicited a great deal of comment and discussion, is a certain atrophy of the interossei muscles of the backs of the hands. A very marked case of this is shown in Figure 3, delineating a case in a Chinaman. He was cheerful, despite his segregation, and

felt in good physical condition. A feature connected with the particular muscular atrophy shown, was a weakness in the grasp of each hand. This peculiar atrophy has an interest for both neurologists and leprologists, from the fact that it is so suggestive of syringo-myelia; and, when the trouble has progressed, or when anesthesia is marked, we may have typical examples of Morvan's disease, so far as appearance and general symptoms are concerned. The first question which arises is as to whether the atrophy is due to leprosy alone, or is there a true syringo-myelia present, produced by the action of the leprosy process on the spinal cord. In regard to Morvan's disease, some have expressed great doubt that it is a disease *per se*. Zambaco Pasha has even gone so far as to assert that all cases of Morvan's disease are in reality leprosy, and that the latter disease can always be demonstrated by tracing back the history of the individual and his predecessors. These questions cannot be considered here, and it will suffice to say that the presence of the atrophic form is prognostic of grave nerve complications, Morvan's disease being an incurable affection and accompanied by varying degrees of imbecility. The whole question is one which has awakened the liveliest interest, and is still being investigated by some of the most competent authorities living.



FIG. 3. Anesthetic Leprosy. (Chinaman.)

No special attempt will be made in this place to discuss the matter, that of the therapeutics of recognized cases being perhaps of more importance. Up to within late years nearly every author regarded leprosy as an incurable disease. Various attempts were made in the way of medication, but no satisfactory or adequate results were obtained. Unna, on the other hand, looks upon the disease as a perfectly curable one, and he claims to have obtained successful results. In view of the results which have been obtained by nearly all those who have attempted to treat the disease, very little encouragement can be held out for an ultimate cure, although improvement can be safely promised and obtained in a comparatively short time. The treatment of Unna, which he has well spoken of, was based upon the researches and findings of a pathologic and of a therapeutic

nature. To begin with, the researches first made by Hensen, and afterwards pursued by other investigators, have proven, with as great a certainty as in the case of tuberculosis, that leprosy is a bacillary disease due to a specific bacillus having peculiarities in its methods of staining, bleaching and cultivating. The bacillus resembles very closely that of tuberculosis in its morphological characteristics, but differs materially from that organism in the fact that cultures can be made only with the greatest difficulty and upon special media. Furthermore, it is ærobic. It is this last quality—this greediness for oxygen—which causes it to assume a particular locality in the tissues. The bacilli hug closely the walls of the arterioles and of the lymphatic vessels. It is this fact which has led to the conclusion that the best treatment is such an one as will rob the organism of the oxygen which it seeks. In order to accomplish this, reducing agents are clearly indicated. Their external and internal use combined should certainly accomplish the desired purpose, if anything can. Good results have been reported as following the use of this method, but, unfortunately, no cure has as yet been accomplished.

The fact that, among our strongest reducing agents, ichthyol holds a foremost place led me to the employment of that agent, both internally and externally, in the case shown in Figure 1. The dosage was carefully and gradually increased, and the patient grew steadily better. She began by taking fifteen grains of ichthyol three times a day, and applied a twenty per cent ichthyol ointment, having a base of equal parts of lanoline and cold cream, twice daily. The internal dose was increased up to one drachm three times a day, at which she remained and continued for quite some time. The ointment was increased to a strength of sixty per cent. A strange circumstance in connection with these high doses of ichthyol was the fact that, far from producing nausea, as might be reasonably expected, the drug seemed to increase the appetite, and the patient declared that she felt much better in every respect. It became occasionally necessary, in the course of the treatment, to suspend the internal administration of the drug, this being done whenever the ichthyolic fetor of the breath became markedly pronounced.

Among the phenomena which were noted in this case, and which were of a most gratifying nature, may be mentioned the return of the sensibility of the skin. The cutaneous anæsthesia, which was complete, disappeared entirely, and the slightest touch of any external body was instantly perceived and recognized. In addition to this, it was noted that the tubercles diminished perceptibly in size, and the face no longer presented the characteristics of the leonine countenance to the same marked degree as it did before the inception of the treatment. After this much improvement had been procured in a comparatively few months' time, the patient passed from under my observation, and I learned later that she had returned to Mexico with the family employing her. This was, of course, quite a disappointment, in view of the progress which had been made, but one which I have experienced in every case of leprosy which I have had occasion to treat.

One of the oldest and, it is claimed, one of the best methods of treatment for this disease is the internal administration of chaulmoogra oil in gradually increasing doses. Many cases of marked improvement have been noted as due to its action, but no undoubted cure has yet been demonstrated.

A remarkable case of improvement, observed in Paris, is reported and figured in the Atlas of Skin Diseases of the Hospital St. Louis, which is still going through the press. There is no doubt that the improvement is remarkable, but the time which has been necessary to accomplish this seems to be almost out of proportion to the result achieved. Another agent which has found many supporters, and which is highly lauded is gurjun oil. It is used very much in oriental countries, as chaulmoogra oil is, both being also quite popular in the Western Hemisphere. We do not see any but encouraging reports; and absolute and undisputed cures have not been brought forward up to the present.

The latest method which might prove successful is that which has been recently brought forward. It is simply the application of sero-therapy to the treatment of the disease. I suggested over a year ago the injection of serum of goat's blood, the animal having been inoculated previously, in the manner employed in other methods of serum injections. All animals being immune to leprosy, a curative as well as preventive serum should certainly be obtainable. Within the past two or three months indefinite reports of successes obtained with goat serum in cases of leprosy have been published. However, so far as an ultimate cure is concerned, but small hope can be held out yet. I have seen two reported cases of cure, but the tubercles had returned and the cases were again suffering from the former symptoms. The structural changes which become established in a case of several or many years' standing are such as to be practically beyond the reach of all treatment. That there is a possibility of preventing the evolution of the disease, when taken at its inception, is most probable. The method of doing this has, so far, not been satisfactorily demonstrated; and leprosy still remains an *odium medicine*, and bids fair to remain so until some effective means of eradicating it is discovered. Whether this will lie in the direction of sero-therapy or of some means as yet undiscovered, must be left for the future. At present, we must, perforce, remain content with the methods at our disposal.

Incontinence of Urine Inherited by an Entire Family from Their Father.—Munro details brief histories of all the members of a family as at present constituted, five girls and one boy (one child died, aged 6 weeks, of whooping cough), all of whom are affected with incontinence of urine. They range in age from 5 to 18 years. The two elder children, girls, are always more affected towards the menstrual period. The incontinence affects most all of the children alike by day and by night. Two of the children were subject to fits, which began during early childhood, and they showed also other signs of degeneracy. The father suffered with nocturnal incontinence until he was a big lad, but not since his wife has been acquainted with him. He is said to be nervous, but is not known to have had fits. A brother of the father and his family, six boys and one girl, are free from incontinence. The patients are seemingly satisfied with their inheritance, being disposed not to persevere with any medication not yielding immediate brilliant results.—*University Medical Magazine.*

STONE IN THE KIDNEY, PRESENTING A CLINICAL PICTURE OF SACRO-ILIAC DISEASE.*

By EMMORY LANPHEAR, M. D., Ph.D., LL. D., St. Louis, Mo.

Formerly Professor of Operative Surgery in the Kansas City Medical College, and Professor of the Principles and Practice of Surgery in the St. Louis College of Physicians and Surgeons.

L. J. R.—, age 26 years, patient of Dr. A. H. Bartmer, of St. Louis, was admitted to the Woman's Hospital, February 19, 1897, with the following history: Health of family excellent; no illness except typhoid fever, four years ago, with uneventful recovery; some fourteen months ago a blow was received in the region of the sacro-iliac junction; two or three months later pain was noted at a point midway between the posterior superior spinous process of the ilium and the fourth lumbar vertebra—just above the sacro-iliac junction; this pain was present only on attempting to lift a weight or to rise from the stooping posture; this continued to increase in intensity until November, when it became sufficiently severe to compel cessation of even light labor; no pain has been felt since except upon motion which necessitates use of the flank muscles; in December Dr. Bartmer found a small tumor somewhat closer to the spine than the location of the pain—situated directly over the sacro-iliac junction, soft, fluctuating and tender, but not inflamed; this tumor increased in size very slowly; fever (100°) was noticed each evening, with slight albuminuria—but no pus in the urine; on account of the albuminuria Dr. Bartmer suspected surgical kidney, but could get no history of renal colic or of pain in the region of the right kidney, nor could he find the slightest tenderness at any point except the sacro-iliac region; some two weeks ago pus appeared in the urine, after which the fever disappeared.

Examination showed a tumor about three inches across, located over the sacro-iliac joint—undoubtedly a collection of pus; much deposit around the joint and a great deal of tenderness below and external to the tumor. The most careful tests gave no evidence of either tumor or tenderness in the region of the kidney, and the patient declared most emphatically that there never had been even the slightest pain either about the kidney or down the ureter—all pain and tenderness had always been at the sacro-iliac joint; upon jarring the pelvis suddenly and severely in such manner as to force the ilium and sacrum together, much discomfort resulted—the pain being referred to the same situation as before.

The age of the patient (young adult life), the history of the case, the character of the pain (a dull, heavy ache increased to acute intensity by action) and its location, as well as its relief by recumbency, and the local appearances, all pointed to sacro-iliac tubercular arthritis, with abscess formation; the only symptoms of a typical case which were absent were (1) atrophy of the muscles of the corresponding leg; and (2) a pronounced limp; and as to the last named there was a very careful, guarded walk, which is found in some cases of sacro-iliac disease instead of the decided limp. The

* Reported to the St. Louis Academy of Medical and Surgical Sciences.

sole symptom which pointed to a kidney lesion, from first to last, was the presence of pus in the urine.

The patient being intelligent and sensible, I explained the impossibility of deciding upon the origin of the pus except by incision, but advised immediate operation, which was accepted. On February 20th, assisted by Drs. G. W. Cale, Bartmer and Hess, I cut down upon the abscess and, beginning at its lower margin, carefully dissected it out. The first sacral nerve was found so tightly embedded in inflammatory deposit as to necessitate at least ten minutes' attention to liberate it without injury. Soon the pus-sac was traced to a point behind the rib—a little above which it turned abruptly toward the kidney. In attempting to separate it from adjacent tissues my finger suddenly broke into the abscess-cavity in the kidney and came in contact with this stone.



Stone Removed From Kidney—Actual Size.

After cutting away the large external pus-sac it was an easy matter to break down the remnants of the cortical arch which laid between the two horns of the stone (each of which projected into one of the calices) and then to remove the calculus. Careful exploration of the pelvis of the kidney with a finger failed to reveal any further trouble; so the diseased pyramids and surrounding cortical substance were gently curetted with the finger-nail, with irrigation; the cavity was then dried and packed with iodoform gauze and the external wound closed except at point of drainage.

There was little hemorrhage and absolutely no shock. Progress toward recovery has been satisfactory in every particular. The albuminuria has disappeared.

The abscess cavity measured seven and one-half inches outside the kidney. The stone is seven-eighths of an inch by five-eighths.

True.—There ought to be a good supply of medical men in St. Louis the first week in April. The Tri-State Medical Society of Iowa, Illinois and Missouri will meet there on the 6th, 7th and 8th, and the Western Ophthalmological, Otological, etc., Association meets there on the 8th and 9th.—*Western Medical Review*.

Missouri Valley Society.—The next meeting of the Medical Society of the Missouri Valley will be held in Lincoln, March 28th. The meeting promises to be a large one. Lincoln being a railroad center, physicians from all parts of the great Missouri Valley will find this meeting easy of access.

MODEL SLIDES FOR THE USE OF STUDENTS OF CLINICAL MICROSCOPY.

By JAMES ALEXANDER CLOSE, M. B., L. R. C. P., Edin.; L. R. C. S., Edin.; F. R. M. S., Lond.; of St. Louis.

I HAVE given the above title to certain slides which I have recently prepared for the use of my private classes in microscopy. While the market is flooded with microscopical preparations (slides) representing every object suitable for examination under the microscope, yet none that I have seen are without certain serious defects.

When a student first commences to use the microscope an entirely new world is revealed to him.

To guide the medical student to the proper interpretation of what he observes is the main reason for the preparation of these specimens.

After a considerable experience in teaching classes in microscopy I have come to the conclusion that a microscopical slide or specimen should possess certain features, which I shall now proceed to discuss in detail:

1st. The specimen should be precisely what it claims to be and nothing else. Therefore, each slide presented to a student for examination should have been previously examined by an expert, and the label attached to the slide should bear his signature.

2d. It should be a typical specimen; i. e., it should show the object so perfectly that it could not be mistaken for anything else.

3d. Each slide should, if necessary, show two preparations of the same object; one should show the object as perfectly as possible, and the other should display the chief errors which the student is liable to make in his examination.

4th. In any slide presented to the student for examination there should be at least one field carefully marked in such a way that it could be easily found by even a beginner; and this field should be a typical one.

5th. As the best modern objectives are corrected for a certain thickness of cover glass, and as a more or less imperfect picture will be shown even by an excellent objective (especially a dry one) if the thickness of the cover glass varies considerably from that for which it (the objective) was corrected, therefore, its exact thickness should be marked upon the slide label or, preferably, upon the slide itself, with a diamond.

6th. The question of the thickness of the cover glass is a very important one from another point of view. When a student undertakes to use a high power objective, say a $\frac{1}{2}$ oil immersion, the danger of injury to the objective by coming in contact with the specimen will bear a direct ratio to the free working distance of the objective—the greater the working distance the less the danger of injuring the objective, and *vice versa*. Now, the only possible way in which the free working distance of any objective, when used with any particular eye-piece, can be increased when used to examine a covered object is by diminishing the thickness of the cover glass. For instance, Zeiss' $\frac{1}{2}$ Apochromatic oil immersion objective of 1.40^o N. A. has an actual working distance of .14 mm. ($\frac{1}{30}$ m.) when

focussed upon an object on the under surface of a cover glass .15 mm. thick, making a total distance between the front surface (mounting) of the objective and the focussed object .29 mm. ($\frac{1}{85}$ inch). Now, if the thickness of the cover glass were to be reduced from .15 mm. to .10 mm., there would be a gain of .05 mm. in free working distance. This increase is, of course, not great, but it materially diminishes the danger of injury to the objective, particularly in the hands of a student not familiar with the use of high powers.

7th. I consider the subject of cover glass thickness so important that I now invariably give to students in my private classes in microscopy slides of bacillus tuberculosis, gonococcus, and other objects requiring the use of high powers, mounted on covers not thicker than .10 mm. to .12 mm. when allowing them to use my high power objectives for the first time; and I have so much confidence in the value of very thin covers for high power work, that I do not hesitate (after a few lessons) to permit a student to focus a $\frac{1}{25}$ immersion lens.

8th. The above statement regarding the value of thin covers may seem to be a contradiction of that made in paragraph No. 5, but it is only in the case of dry, and to a slightly less degree of water, immersion objectives that the necessity exists for carefully adjusting the thickness of the cover glass to that for which the objective was corrected by the maker. In the case of homogeneous (oil) immersion objectives the perfection of the microscopic picture (definition) will not suffer even if the thickness of the cover glass varies within wide limits from that for which the objective was corrected. (Say from .10 mm. to .20 mm. in the case of an objective corrected for a cover glass .15 mm. thick.) When the oil immersion objective is used the thickness of the cover glass makes but little difference, as far as definition is concerned, but it is of the greatest moment if we consider the safety of the objective.

I have purposely dwelt extensively upon this subject of cover glass thickness, because when we consider that the best oil immersion objectives now made cost all the way from \$38 to \$200, any instructions which will enable the student to protect his objective from injury must be valuable.

9th. A certain area of the cover glass should be marked in such a manner that it can be easily found, even by a beginner, and a description of the objects found in this area should accompany the slide.

The only satisfactory method of marking a specimen that I am acquainted with is by means of Winkel's marker.

With this instrument a circle may be scratched with a diamond upon the cover glass. This circle is permanent, and can be easily found with a 1 inch or $\frac{2}{3}$ inch objective and low eye-piece, or with even a watch-maker's lens.

Having been found with a low power the $\frac{1}{6}$ or $\frac{1}{12}$ oil immersion may be focussed upon it and the described objects will be seen.

10th. The glass slide itself should, of course, be free from imperfections (bubbles, etc.), and the edges should be smooth, but whether of the beveled-edge or ordinary variety makes little difference.

A few years ago I had made for me by the Palmer Slide Company an exceedingly thin slide, 2x1 inches, and .20 mm. ($\frac{1}{25}$ m.) or .30 mm. ($\frac{1}{3}$ inch) thick. Specimens of bacillus tuberculosis, gonococcus, etc.,

mounted upon these slides, when examined with an apochromatic oil immersion of 1.40 N. A., and when connected with the Abbé condenser by a drop of cedar oil, give the most perfect picture of these organisms attainable. But they are so easily broken that it is doubtful if it would be advisable to give them to a student for purposes of study.

11th. As regards the variety of objects which should be furnished to the student, it may be said that it should embrace every object of interest to the clinical microscopist. The following list should, however, be most carefully studied:

1. Bacillus tuberculosis.
2. Gonococcus.
3. Urinary sediments.
4. Blood.

12th. The above list includes all the specimens which I have prepared (as models) up to date. I propose to extend the list very considerably.

The greatest difficulty is experienced in the case of slides of urinary sediments. These should be mounted in a fluid medium which will not change their appearance. I am not yet quite certain of the degree of success which I have attained in the mounting of these specimens, but I have kept slides for several months without material change. I am now experimenting with various preservative solutions (formol, bichloride of mercury, etc.).

13th. Each "model" slide of bacillus tuberculosis contains two covers (specimens). Each cover is $\frac{3}{8}$ inch in diameter. One is stained by a rapid method, say the Hartzell method, and the decolorization of this specimen is purposely defective (in order to illustrate the most frequent mistakes of the beginner); the other is stained by the Koch-Ehrlich-Weigert method, and is in every respect as perfect as the preparer is capable of making it.

No cover glass having a thickness greater than .12 mm. ($\frac{1}{200}$ inch) is used. The covers are carefully centered, and an effort has been made to make the mechanical work as perfect as possible.

14. Mr. O'Hara, who has assisted me in my laboratory for the last fifteen years, has undertaken the preparation of these slides. I shall, however, examine each slide, and shall attach my signature to it before it is sent out.

Announcement by the Mercer Chemical Co.—Physicians who dispense their own medicine can save money by using a little care when making their purchases of pharmaceuticals. Most manufacturers allow the physician a discount of only 25 per cent from the usual list. The Mercer Chemical Company, of Omaha, list their goods at the usual prices of all manufacturers and allow the dispensing physician a discount of 40 per cent. In other words, the physician can save fifteen per cent on every dollar by sending his orders to The Mercer Chemical Company. Their goods are guaranteed to give satisfaction or no pay expected. It will pay you to send them a trial order at once, as at the present time they offer as a special inducement for mail orders to present one gallon of syrup of white pine compound free of charge with every order for pharmaceuticals amounting to \$20.00 net.

A CASE OF INGUINAL RETENTION OF THE TESTICLE COMPLICATED BY DIRECT INGUINAL HERNIA.

By GEO. W. CALE, M. D., of St. Louis.

O. C., a young man aged 22 years, was brought to me by Dr. Carl Pesold some four weeks ago. The patient is a locomotive fireman and complained of pain in a swelling in the right inguinal region; the pain seemed to have no connection with the labor performed, as at times it was worse during the restful hours.

Examination revealed a smooth, almost round, tumor about the size of a small orange, which occupied the site over the inguinal canal. The tumor was tense, elastic and somewhat tympanitic. By deep palpation over the upper and outer part of the swelling, the testicle could be made out, and the same sensation was produced as when the normally situated left testicle was squeezed. Numerous attempts had been made to reduce the contents of the lower part of the swelling by various surgeons, but without avail. We decided to operate, and made a four-inch incision over the tumor in the direction of the inguinal canal. We found the testicle and its coverings adherent in the canal, just outside of the internal ring. Occupying the lower part of the canal, and in no way connected or associated with the testicle, was a large mass of congested adherent omentum, which had entered the canal directly through the external ring.

This piece of omentum was tied off in about six sections and removed. The stump was then pushed in the abdominal cavity. The testicle was next removed, the sac dissected up and cut off; the stump was then fixed at the abdominal side of the internal ring—not in the ring itself. The rings and canal were then closed by buried silk sutures, and the canal and external wound closed together with silk-worm gut.

The latter sutures were allowed to remain nearly three weeks, and when removed there was neither sign of stitch, abscess, or cutting of the tissues. The patient was kept in bed over three weeks, and shows now a very deep, firm scar. The testicle on section had a yellowish fatty appearance.

New Instrument Firm.—The genial Dr. J. W. Moore, who was for many years a moving spirit in the Holeykamp-Moore Instrument Co., has severed his connection with that firm, and has gone into business with Mr. Bles, under the firm name of The Bles-Moore Instrument Company. The new firm is pleasantly located at 213 North Tenth street, St. Louis, where physicians and surgeons will find a new and complete stock. The best wishes of Dr. Moore's many friends will go with him, and we predict that the new firm will meet with great success.

OPHTHALMOLOGICAL NOTES.

By JAMES MOORES BALL, M. D., of St. Louis,

Professor of Ophthalmology in the St. Louis College of Physicians and Surgeons.

Treatment of Asthenopia.—Dr. Wheelock Rider, of Rochester (*Buffalo Medical Journal*, March, 1897), says:

“Now, let me briefly state the method for treating these asthenopic patients which seems to me to be rational, and which, judging from results, I consider to be entirely adequate. First, however, in order that the importance of a proper treatment may be realized, I will say that fully three-quarters of my patients desire relief from asthenopia.

“I first ascertain whether or not the general condition of the patient warrants the exertion he demands of his eyes. If it does, I learn whether or not the ciliary muscle is correcting hypermetropia, hypermetropic astigmatism or presbyopia, in addition to its normal function of controlling accommodation. If deformity is excessive, *i. e.*, is more than is usual in the average man, glasses are ordered for close work or to be worn constantly, as the exigencies of the case demand. A mydriatic is necessarily used in all eyes not presbyopic. If the deformity be slight, the patient is told to get into training, assured that a physiological fatigue will limit overwork, but that bedridden eyes are frequently seen.

“I have no desire to enter the lists to combat the intenable proposition that in graduated tenotomies of the ocular muscles we have a patent remedy for chorea, hystero-epilepsy, chronic constipation and insanity. All this and more has been asserted, but I believe it to be so absurd as to ensure its own destruction. However, such specious argument is made in so many quarters for tenotomies to relieve muscular asthenopia, so many patients are subjected to the risks of useless operations, and it all is, it seems to me, so far from truth, that I have, after observing in wonder and silence for many years, ventured to present the matter for your consideration.

“With all due modesty, I wish to place myself on record in 1896 as saying that graduated tenotomy for the relief of asthenopia is, as a rule, irrational and dangerous.”

Test Cards With Black Background.—Gould (*Annals of Ophthalmology*, January, 1897) calls attention to the fact that in subjective tests for ametropia where weariness is due to excessive stimulation of a large part of the retina by the white backgrounds of the test cards, it is of advantage to use cards presenting white letters on a black background. Black surfaces absorb light, and consequently rest the retina. Such cards were in use twenty years ago, but fell into disuse, probably on account of the difficulty of manufacture.

Study of the Ophthalmic Conditions in a Case of Cerebellar Tumor.—In the *Univ. Med. Mag.*, Oliver reports a case of a male, aged 38 years, with the history of an injury of the head received seven years before. Beneath the under surface of the cerebellum there was an oblong tumor $5\frac{1}{2}$ cm. in

length, and $2\frac{1}{2}$ cm. in breadth at its widest part. The growth sprang from the under and external surface of the middle cerebellar peduncle, and projected outwardly between the pons varolii, the medulla oblongata and the right cerebellar lobe. The spinal cord, which was œdematous, gave evidences of degeneration of its lateral columns. The tumor was a gliosarcoma undergoing cystic degeneration. This case is of interest, not only upon account of the usual history of trauma and the characteristic general symptom of cephalalgia, mostly in the region of the occiput, but the vertigo, the ataxic gait, with exaggerated patellar-tendon reflex; the tonic convulsive movement of the head and trunk to the right; the high grade of optic neuritis; the almost absolute blindness, usually typical of sub-tentorial pressure; the shape and position of the field remnant in the left eye; the nearly total internal ophthalmoplegia—all make an ocular picture that is eminentiy of value in the determination of the situation of intracranial growths.

Trachoma Treated With Injections of Permanganate of Potassium.—In a paper read before the Pan-American Medical Congress, held at Mexico City, November, 1896, Dr. Juan Santos Fernandez, of Havana, Cuba, advocates injections of permanganate of potassium into the fornix, which adds another method of treatment for this troublesome and unmanageable affection. These injections seem to be attended with severe pain, which, however, may be modified by the previous instillation of cocaine.

A Modern Pharmacy.—Ferd. C. Pauley, dispensing chemist and pharmacist, Southeast corner of Grand and Franklin avenues, has, since the 25th of February, placed in stock a complete and full line of preparations manufactured by the well-known firm of Parke, Davis & Co., Detroit, Michigan. This line embodies antitoxine serum syringes, hypodermic syringes, and all sundries and specialties manufactured by the above-named firm; also, a complete line of all hypodermic tablets, which is the most complete list manufactured.

In drawing the attention of the medical profession to the above, we wish, also, to state that Mr. Ferd. C. Pauley makes it a point to carry in stock the most complete line of all drugs and chemicals, which give him an unequalled facility for the dispensing of prescriptions which are entrusted to his care.

And purchasing goods direct from manufacturers enables him to supply fresh, and probably more active, drugs and chemicals than can, in most cases, be obtained elsewhere.

Nebraska State Society.—The Nebraska State Medical Society will meet in Lincoln, on May 18, 19 and 20. While that is several weeks ahead, it is not too long for those who take an interest in it to begin to prepare their papers. According to a resolution adopted at the last meeting of the Society, the meeting this year will be held in two sections, one designated surgical, the other medical. For this reason nearly twice the amount of work can be accomplished, and there will be no danger of too many papers.

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A PROGRESSIVE HOUSE.

The well-known firm of Parke, Davis & Company, of Detroit, has had such a great increase in its business in St. Louis and adjacent territory, that the establishment of a St. Louis office has been a necessity. Their representative, Mr. Fred S. Carter, is pleasantly located in the Chemical building, Olive and Eighth streets, where the friends of the house are invited to call. Physicians will find Mr. Carter a genial gentleman, fully in touch with the profession, and anxious to advance its best interests.

PRIZE OFFER.

The Resinol Chemical Co., Baltimore, Md., are offering six very handsome prizes for clinical reports on their preparation, Unguentum Resinol, in the various skin diseases. The preparation is an effective remedy, and the Resinol Company hope to encourage physicians who have used the preparation by offering the prizes heretofore mentioned. The prizes offered are as follows: First prize, \$100, for the best report of not less than five cases; second prize, \$60, for the next best report of not less than five cases; third prize, \$75, for the best report of not less than three cases; fourth prize, \$40, for the second best report of not less than three cases; fifth prize, \$50, for the best report of a single case in which Resinol was used; sixth prize, \$25, for the second best report of a single case in which Resinol was used. All articles must be received by the Resinol Company by May 15th. The offers are made to all practicing physicians. The advertisement of the company can be seen in another part of this issue.

SKETCH OF PROFESSOR AUGUSTUS CHARLES BERNAYS, SURGEON.

AUGUSTUS CHARLES BERNAYS, member of the Royal College of Surgeons of England, and one of the greatest surgeons in the world, is a resident of St. Louis. Of a striking personality, now in the prime of life, of fine physique, with a clear brain and a hand whose dexterity is marvelous, Dr. Bernays is one of the glories of this splendid city.

The subject of this sketch first saw the light of day at Highland, Illinois, October 13, 1854. His father was a distinguished physician and was a professor in the old Humboldt Medical College, while his mother was a woman of great culture. Young Bernays was carefully instructed in English, French and German at an early age. After passing through a grammar school in this city he was sent to McKendree College, Lebanon, Illinois, where in his eighteenth year he was graduated A. B. The fall of the same year he went to Germany and entered the University of Heidelberg as a student of medicine. At the end of four years he received the degree of Doctor of Medicine, graduating with the highest honors, being the first American on whom the "*summa cum laude*" was conferred by the University. He was made assistant to two noted German surgeons of that day, viz.: Professors Gustav Simon and Hermann Lossen.

Returning to St. Louis, Dr. Bernays began the practice of surgery, meeting with the greatest success from the very start. He was the first St. Louis surgeon to successfully perform many of the major operations. In 1883 he was elected Professor of Anatomy and Clinical Surgery in the College of Physicians and Surgeons, which was then a young and struggling institution. He brought to his work accurate knowledge, great enthusiasm and the ability to toil while others were at rest.

The contributions which Dr. Bernays has made to the literature of anatomy and surgery would fill a volume.

Partial list of the important contributions to anatomical and surgical science by Prof. A. C. Bernays:

1. On the Development of the Auriculo-Ventricular Valves of the Heart—*Morphologisches Jahrbuch*, 1876.
2. On the Development of the Joints—*Morph. Jahrbuch*, 1877.
3. On Ideal Cholecystotomy.
4. On Gastrostomy for Foreign Bodies.
5. On Vaginal Hysterectomy.
6. The Enucleation of Fibroids per Vaginam.
7. Series of Cases of Gunshot Wounds of the Abdominal Viscera.
8. On Myo- and Tendoplastic Operations.
9. The Pathology and Treatment of Urethral Strictures.
10. The Treatment of Pseudarthrosis and Ununited Fractures.
11. Resection of the Pylorus.
12. Cases of Curettement of Gastric Cancer.
13. Total Excision of the Tongue for Cancer.
14. Cæsarian Section for Placenta Prævia.
15. Operations for Neurectomy of the Fifth Pair.



*Dr. A. C. Bernays.
St. Louis, Mo.*

16. Cases of Hysterectomy with Nephrectomy and Uretero-plasty.
17. Osteoplastic Operations on Skull.
18. Operation for Impermeable Stricture of Œsophagus.
19. Operation for Kidney Stones.
20. Cases of Enamelogenous Cysts of the Lower Jaw.
21. Nephrectomy for Traumatism of the Kidney.
22. An Operation for the Cure of Retroflexion.
23. Relief of Tic Douloureux by Nephrectomy.
24. Case of Bronchial Tumor of the Neck.
25. Cases of Demedullization of Long Bones.
26. Report of Cases of Operations in Ruptured Extra-Uterine Pregnancy.
27. Operations for Lymphosarcoma of the Neck.
28. Report of Cases of Nephrolithotomy.
29. On the Best Method of Practical Asepsis—and many others.

The first successful cœliotomy for gunshot wound of the abdomen, in Missouri, was done by Dr. Bernays; so, also, the first gall-stone operations, and the first successful Cæsarian section in St. Louis, was done by him, as well as the first vaginal hysterectomy; in fact, he has been the leader in the advancement of surgery under the antiseptic and aseptic régime in St. Louis and the southwest.

Dr. Bernays is a trenchant writer. The following thoughts are from his farewell remarks to the class of '96 of the Marion-Sims College of Medicine:

“Remember that it makes no difference at all what a man believes, but a great deal what he knows.

“Remember that after to-night you must give up text-books in order to study nature. The only way in which you will be able to advance the interests of our profession will be by adding to our knowledge; the only way in which you will be able to do that, will be by using your trained senses in observing facts and by recording your observations and reflections in a scientific medical journal.

“Remember that the way to conquer prejudice is to live it down. Do not discuss it with others, waste no thought on it yourself.

“Remember that it is brave to be in the minority. That is where the strong usually are. Weak natures cannot stand alone, but must lean on the majority.

“Remember that it is the nature of science to ignore authority, to look away from it, to pursue its own course in order that it may arrive at the highest and most important truths without prejudice.

“Finally, gentlemen, remember ‘there is no darkness but ignorance,’ and remember in your toilsome professional career to shed as much light along your course as you may be able to create or to reflect. Remember my oft repeated commandment: Scientific truths must be freely given away; they are priceless, and one who trades in them is unworthy of the ware. Give them to others just, as you have received them from me at this college from which you have graduated to-night. I hope that the wants of your bodies and the hunger of your minds may be satisfied, so that you will be happy enough to make others happy.”

SEMI-CENTENNIAL MEETING AMERICAN MEDICAL ASSOCIATION
JUNE 1st, 1897, PHILADELPHIA, PA.

SPECIAL TRAIN, SPECIAL TIME, SPECIAL PLEASURE.

The coming Semi-Centennial meeting of the American Medical Association, to be held in Philadelphia, June 1st to 4th, will undoubtedly be the most interesting meeting of the Association that has been held in recent years; the place of holding the meeting, Philadelphia, the time of the meeting, June, and the programme, all indicate it.

The trip will be a delightful one, and you should begin now to make your arrangements so that nothing shall prevent your going.

In order that a jolly, congenial party may be organized and the trip be made a real pleasure trip, the TRI-STATE MEDICAL JOURNAL has arranged with the Big Four Route and Chesapeake & Ohio Railway to provide as many special sleepers for the exclusive use of the party as may be needed, and also arranged to have them leave St. Louis on the Knickerbocker Special on the Big Four route at 12.00 noon Sunday, May 30th, and reach Philadelphia next evening at 7.04. This will insure every one from the West and Southwest arriving in time to join the party here.

Arrangements are being made to have the delegations from Indianapolis, Cincinnati, Louisville and other places join us en route, and we will probably have a special train from Cincinnati east. The one-way rate from St. Louis to Philadelphia is \$20.50 via the route we have selected, and we hope to get a rate of one fare for the round trip, but in any event we are sure of a rate of one and a third fare for the round trip on the certificate plan.

The return tickets will be good to leave Philadelphia as late as Tuesday, June 8th, and you will be given the privilege of stopping off at Washington for several days to see the many attractions that the Capital City presents.

The Chesapeake & Ohio Railway is essentially a tourist's route, and it is at its best in the charming month of June. The road is lined with famous health and spring resorts of especial interest to physicians, among which are White Sulphur Springs, the Hot Springs of Virginia, and many others. You can stop off at the Hot Springs on your return trip; it will pay you to see the magnificent new bath houses, the elegant new hotels, and the miles of broad boulevards that have recently been constructed there. The magnificent scenery will charm you, the pure mountain air will invigorate and refresh you, and you will find it a delightful spot.

The Chesapeake & Ohio Railway has been justly christened "The Rhine, the Alps, and the Battle-field Line of America," and the extent and variety of the scenery along the upper Ohio, the great Kanawha, through the cañons of the New River, over the peaks and through the valleys of the Alleghany and Blue Ridge mountains, and the historic battle-fields of the plains of Virginia, cannot be duplicated in a journey of equal length on any other railroad in America.

The cost of a double berth that will accommodate two people in the

through sleeper from St. Louis to Philadelphia will be \$6.00, and we would suggest that you have a berth reserved by sending in your name to Otho F. Ball, Business Manager TRI-STATE MEDICAL JOURNAL, who will arrange for your accommodation on the special sleepers from St. Louis; and if you find that you will be unable to go you can cancel the reservation later. Dr. Ball will cheerfully send you descriptive matter and time tables of the route on application.

COMMENCEMENT OF THE ST. LOUIS COLLEGE OF PHYSICIANS AND SURGEONS.

On the evening of March 17th, the St. Louis College of Physicians and Surgeons graduated a class of sixty-four gentlemen. To the credit of the school, it must be said that four men dropped out of the class before examination day, while of those who stood the test, seven were "plucked." The aim of the present faculty is to make the school the peer of any in the country. The exercises were conducted under the direction of the Dean, Dr. Waldo Briggs, the well-known surgeon. The faculty valedictory was delivered by Dr. R. M. King, who gave a masterful discourse upon "Hippocrates and His Code." The class valedictory by Dr. M. A. Finley was a gem. The "florist" was Professor Thomas Osmond Summers, who aroused great enthusiasm, particularly by his reference to the uprising in Greece. A pleasing feature was the presence of the founder of the school, Dr. Louis Bauer, who is alert and active at his eighty-fourth year.

First honors—an elegant gold medal—were carried off by Dr. Otho F. Ball, Business Manager of the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER. For the second prize two gentlemen tied: Drs. L. A. Bolling and J. N. Beasley. Dr. J. A. Walker was given honorable mention.

Well Done.—The State Board of Examiners of New York, in a report made to the Medical Society of New York, two weeks ago, states that since the establishment of the board, in 1893, 2,832 persons had applied for license to practice medicine, and of these 927, or 29.7 per cent, had been rejected as incompetent. Query: Where did these 927 go?

Serum Therapy in Puerperal Fever.—Butin (*Journ. d. Sc. Med. de Lille*, No. 35, 1896) gives details of two cases of puerperal fever treated successfully with Marmorek's anti-streptococcic serum. In the first instance the treatment was not begun till more than a week after the commencement of the fever, and after sundry relapses and the injection on five occasions of the serum to the total amount of 90 c.cm., the patient recovered. In the second the injections were made at once, and the disease was almost cut short. In both cases local treatment, consisting of sublimate intra-uterine douches and iodoform crayons, was, contrary to the advice of Marmorek and Roux, continued throughout. It is, therefore, impossible certainly to ascribe the recovery to the serum, but it was noted that the temperature and the general condition greatly improved after each injection of the serum. In the first instance slight erythema and transient arthralgia were caused by the injections; in the second there were no troubles, either local or general.

HISTORICAL SKETCH.

WHO DISCOVERED ANÆSTHESIA?

By JOSEPH H. HUNT, M. D., of Brooklyn, N. Y.
Chairman Historical Committee, Medical Society County of Kings.

[CONTINUED FROM THE FEBRUARY ISSUE.]

Dr. Laird W. Nevius, of Chicago, in his interesting and valuable little book on the "Discovery of Modern Anæsthesia" (which is the only real impartial account of the discovery that I have read), after speaking of Dr. Bigelow's paper being published in the *Boston Medical and Surgical Journal*, November 9, 1846, says: "A copy of this journal was sent to Dr. Booth, of London. As soon as Dr. Booth had read the article, he communicated the important intelligence to Dr. Liston, the distinguished surgeon of the University College. On the 21st of December, 1846, Dr. Liston practically and successfully tested the discovery, and immediately communicated the fact to a former pupil of his, Professor Miller, of Edinburgh, in the following enthusiastic words: 'Hurrah! rejoice! Mesmerism and its professors have met with a heavy blow and great discouragements. An American dentist has used ether (inhalation of it) to destroy pain in his operations, and the plan has succeeded. Yesterday I amputated a thigh, and removed, by evulsion, both sides of the great toe-nail, without the patients being aware of what I was doing, so far as regards pain. The amputation-man heard, he said, what was said, was conscious, but felt the pain neither of the incisions nor that of tying the vessels. I mean to use it again to-day. In six months no operation will be performed without this precious preparation. Rejoice!

'Thine always, R. L.'"

In the last number of the *British Medical Journal* we get an echo from that first operation.

Sir Joseph Lister, in his address before the British Medical Association, from which I have already quoted, said: "I witnessed the first operation in England under ether. It was performed by Robert Liston, in University College Hospital, and it was a complete success. Soon afterwards I saw the same great surgeon amputate the thigh as painlessly, with less complicated anæsthetic apparatus, by aid of another agent, chloroform, which was being powerfully advocated as a substitute for ether by Dr. (afterwards Sir James Y.) Simpson, who also had the great merit of showing that confinements could be conducted painlessly, yet safely under its influence."

Simpson first employed ether anæsthesia in midwifery, in Edinburgh, January 19, 1847, but two months and three days after its first use as an anæsthetic in surgical operations at the Massachusetts General Hospital. It was soon recognized, however, that sulphuric ether had its more or less unpleasant side for this use, an Dr. Simpson cast about for a more agreeable substitute. His attention was called to the experience of a surgical pupil of Dr. John Bell. It seems that after the anæsthetic properties of

ether had been announced, "this young man exhibited such a passion for the article that Dr. Bell, fearing some accident, gave strict orders that he should not be allowed access to the ether bottle. Hunting through the cellar of the shop, he was fortunate enough to discover a bottle labeled 'chloric ether'—the name by which chloroform was then known. The adventurous student immediately made trial of its contents, and succeeded in procuring an insensibility that was more agreeable than the anæsthesia which had followed the inhalation of ether." (Lyman on Artificial Anæsthesia and Anæsthetics, Wm. Wood & Co., New York, page 8.) On November 15, 1847, came Dr. Simpson's first opportunity to use the new agent. It was on three cases in the Royal Infirmary, Edinburgh. In two of the cases Professor Miller, to whom Robert Lister had written the enthusiastic letter quoted from, was the operator, and the other was a case of Dr. Duncan's. It so happened that among the spectators was Professor Dumas, of Paris, the chemist who had first ascertained and established the chemical composition of chloroform. He happened to be passing through Edinburgh, engaged in an official investigation for the French government, and was in no small degree rejoiced to witness the wonderful physiological effects of a substance with whose chemical history his own name was so intimately connected. That since then it has been the almost universal anæsthetic in obstetric work, is well known.

Sir James Y. Simpson, in his work on Anæsthetics, relates several instances of the narrow escape chloroform had of being condemned in the very conception of its use. I quote as follows:

"After the discovery of the anæsthetic effects of chloroform, I was of course anxious to get it tried in a surgical operation. Two days previous to that on which the first cases were operated upon, an operation took place in the Infirmary, at which I could not be present, to test the power of chloroform; and, so far, fortunately so; for the man was operated upon for hernia, without any anæsthesia, and suddenly died after the first incision was made through the skin, and with operation uncompleted." In another case, a patient was urged by her physician to take chloroform for the purpose of having a tooth extracted which had worn her out with the pain. She postponed it for a few hours, meanwhile retiring to her bed in order to obtain some rest before undergoing the test. On going to her room, an hour or two subsequently, she was found dead. In another case, death instantaneously followed the use of an abscess lancet, without chloroform, the practitioner deeming it unnecessary to use anæsthesia in so slight a case.

What more desirable sponsor could the new discovery have than the genial "Autocrat of the Breakfast Table."

After Morton had demonstrated the value of his agent to the surgeons at the Massachusetts General Hospital, and it began to assume some importance, he found that it needed a name. He called upon several of his friends, who made list of certain words significant of the subject. The cognomen chosen by Morton was "Letheon," and under that title he secured his patent.

Edward Warren, in his pamphlet, "Some Account of the Letheon," gives an interesting letter from Oliver Wendell Holmes, from which the following is quoted:

BOSTON, November 21, 1846.

My Dear Sir:

Everybody wants to have a hand in a great discovery. All I will do is to give you a hint or two as to names—or the name—to be applied to the state produced and the agent.

The state should, I think, be called "Anæsthesia." This signifies insensibility—more particularly (as used by Linnæus and Cullen) to objects of touch.

The adjective will be "Anæsthetic." Thus we might say the state of anæsthesia, or the anæsthetic state. The means employed would be properly called the anti-anæsthetic agent. Perhaps it might be allowable to say anæsthetic agent, but this admits of question.

Yours respectfully,

O. W. HOLMES.

Dr. Morton.

Who recognizes it by the name disgraced by secrecy and a patent-right to-day? The name bestowed by the literary taste of Dr. Holmes has been accepted the world over.

In connection with Holmes, the following is from his introductory lecture before the medical class at Harvard University, November 3, 1847, one year after Morton's first experiment: "The knife is searching for the disease, the pulleys are dragging back the dislocated limbs—Nature herself is working out the primeval curse which doomed the tenderest of her creatures to the sharpest of her trials; but the fierce extremity of suffering has been steeped in the waters of forgetfulness, and the deepest furrow in the knotted brow of agony has been smothered forever." (Quoted from Dr. Hayden's Anæsthesia.)

At the time the wealthy Thomas Lee bequeathed \$10,000 to commemorate the discovery of the anæsthetic power of ether, he and the general public supposed that the idea that nitrous oxide gas was an anæsthetic had been given up. Wells was dead, by his own hand, while confined as a lunatic in a New York prison, and Morton, Jackson and Long, in their fights before Congress and elsewhere for recognition had ignored and suppressed all knowledge of it. Therefore the donor left his money to erect a monument to the principal of the three more commonly used anæsthetics, and mentioned the name of no one, and in the public ceremonies at the unveiling of the monument, it is said that the names of the individuals who may have discovered "that the inhaling of ether causes insensibility to pain," were carefully—not mentioned.

In view of the acrimonious discussions over the subject, it may be best that the purity of the Ether Monument should remain untarnished by the name of one of the discontents. If it must bear the name of the discoverer of anæsthesia by means of sulphuric ether, let it bear those of Michael Faraday, Drs. Crawford W. Long and W. T. G. Morton.

If the monument had been erected in memory of the discovery of anæsthesia, it should bear the additional names of Sir Humphrey Davy, M. D., Gardner Q. Colton, and Dr. Horace Wells.

Let his name be placed *among the rest*, notwithstanding the fact that there are those who believe that his rights were forfeited by his attempted secrecy, which was broken and given to the world by Dr. Bigelow and the other Boston surgeons who published at once accounts of its use in their surgical work. He gave the priceless gift to humanity when he found that the Massachusetts General Hospital would have nothing to do with a secret anæsthetic, and the United States Court would not recognize the validity of his patent.

Dr. Charles J. Jackson only gave Morton the information he had

gained from Farraday and scientific teachers after him, and was shared by scientific students the world over.

Of the men who were most active in this exciting drama, Horace Wells, died, as already stated, as an insane suicide, January 24, 1848.

The City of Hartford and the State of Connecticut have erected in Bushnell Park, Hartford, a bronze statue of Dr. Wells, with this inscription:

HORACE WELLS,
WHO DISCOVERED
ANAESTHESIA.
NOVEMBER, 1844.

Dr. Jackson also became deranged, and died August 28, 1880, in the McLean Asylum, a department of the hospital so often alluded to, where Morton-Jackson's first experiments were made.

Dr. Morton (he received the honorary degree of M. D. from the Washington University, Baltimore, in 1848) died July 15, 1868, either in Central Park, New York City, or in an ambulance while being carried from there to St. Luke's Hospital, in a fit of delirium from some acute brain trouble. In Mt. Auburn Cemetery, Boston, a beautiful monument bears this inscription:

W. T. G. MORTON,
BORN AUG. 9, 1819.
DIED JULY 15, 1868.

*Inventor and revealer of anæsthetic inhalation, before whom in all time surgery was agony; by whom pain in surgery was averted and annulled; since whom science has control of pain.
Erected by citizens of Boston.*

Dr. Morton received a recognition in the shape of a share of the Montyon prize, amounting to 2500 francs, from the French Academy, a silver casket containing one thousand dollars from the trustees of the Massachusetts General Hospital, and other citizens of Boston; the order of St. Vladimir from Russia; and the order of Vasa from Sweden.

Though Dr. Jackson's connection with the discovery was but that of a consulting chemist, he received foreign honors in excess of the others. They include the Cross of the Legion of Honor from France, the Order of the Red Eagle from Prussia, and other orders and medals from Turkey, Italy, and Sweden, besides sharing the Montyon prize of 5000 francs with Dr. Morton.

Though this paper has already reached a length much in excess of the writer's original plans, he is unwilling to bring it to a close without some additional reference to the only one of those whose names have been prominently connected with this tragic history, who is still living, though nearly three years past the four-score allotted to the best of men.

When Dr. Horace Wells gave up his life, anæsthesia by the administration of nitrous oxide died with him.

Gardiner Q. Colton, who had been the original agent in introducing it to Dr. Wells, gave up the lyceum platform in 1849, and joined that tide of people, who were attracted to the golden sands of California. We do not

learn that he ever delved with pick and shovel, but know that he was an adjuster of the misunderstandings of those who did, for he was the first Justice of the Peace in San Francisco, and we do not think that any of his decisions were ever reversed by a higher court. In a few years he returned



Sir James Y. Simpson.

to the east, but soon lost his Californian wealth in the salt springs of Syracuse, N. Y., and returned to his former occupation as a scientific lecturer. Though he was accustomed to tell his audiences of the anæsthetic properties of the laughing-gas, no one became enough interested in it to desire a repetition of Dr. Wells' fateful experience.

It was not until June, 1863, again in the State of Connecticut, that Dr. J. H. Smith, a New Haven dentist, concluded to try the gas, and again Mr. Colton was requested to administer it. Again it was a success, and such was the fame that this second-time discovered anæsthetic agent brought to Dr. Smith and Mr. Colton that they, in the twenty-four days which they continued to operate together in New Haven, extracted over three thousand teeth under the anæsthetic influence of nitrous oxide.

Mr. Colton abandoned his other scientific work, and came to New York City and organized the great dental association which bears his name, and where the nitrous oxide has been administered to nearly 200,000 patients without their having had the misfortune to meet with a serious accident.

Nitrous oxide is now used in nearly every operating dentist's office in the world, and their use of it dates from the rediscovery in 1863.

Mr. Colton was in early life a medical student in one of the colleges of New York City, with the late Willard Parker for a preceptor, but funds became low, and as he had been a leader among the students, experimenting with laughing gas, he was persuaded by them to arrange a public exhibition, which proved to be such a financial success that it was repeated with various scientific variations until they resulted, as has been shown, in twice introducing nitrous oxide as one of the triumvirate of anæsthetics.

Both Morton and Wells were given the honorary title of M. D. in acknowledgment of their services to our profession; and the qualified institution which confers a similar degree upon Gardner Q. Colton, will honor itself and medicine more than the modest gentleman who has given a longer period of his life than is allowed to many of us to the study and development of anæsthesia.

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter IV.

WRAPPERS.

ASTONISHING! How much can be said on the subject of "Wrappers!" Webster's definition of a wrapper is—1. "That which, or one who wraps. 2. That in which anything is wrapped or enclosed; envelope or covering."

As there are so many varieties of wrappers, by way of introduction it is best to explain that those with which we are to deal are the paper wrappers in which medical reprints are enclosed. They may be had in an unending variety of materials, colors, and such sizes or shapes as the sender may select. There is no general rule in regard to wrappers; the United States postoffice one-cent wrapper may be used as a pattern, but it is by no means artistic, nor does it answer all purposes.

The uses of a wrapper, as viewed by the author, are: 1. To protect that which it encloses. 2. To bear the name and address of the receiver. 3. It should also bear the name and address of the sender, as well as the title of the article which it encloses. Furthermore, it should be of attractive appearance and of such quality that it will receive more than an indifferent glance from its recipient—the reason is obvious. A pamphlet which comes enclosed in a common wrapper, may be regarded as a cheap advertisement of the patent medicine class and cast into the waste-basket without further consideration, as a busy physician has no time to spare over this kind of literature. Our first-class business houses send out their announcements in attractive form, and why should not the *physician* do the same?

I have received medical reprints not only from abroad, but also from the east, from well known authors, who are regarded with profound respect by all members of the profession, with the full name of the sender and title of the article upon the wrapper; this method is also observed by the younger members of the profession, whose reputations are thriving; knowing from whom the article comes, it is carefully preserved; this custom is becoming general, and when a custom is once established it is regarded as an unwritten law. Let us be progressive, but at the same time observant of the code.

The titles of many of the leading medical publications appear upon the wrappers in which they are mailed; for example, the Journal of the American Medical Association. Can any objection be raised against this? One may as well object to the rule of the sender's name and address appearing upon an envelope, but Uncle Sam says you must put it on.

The preceding remarks are made for the understanding and consideration of what is to follow.

A well-known St. Louis surgeon, who from time to time reads a paper before some medical society, giving his experience to the profession according to the medical ethics and the Hippocratic oath, frequently sends out reprints to the profession; his name, address, and the title of the reprint invariably appear in the upper left-hand corner of the wrapper; for instance—"Fractures," "Dislocations," "Home Again," "Tumors," etc. If these are not delivered, they are promptly returned to the sender.

At the meeting of the State Medical Association at H., there was present a very ambitious member—if I am not mistaken, a professor of diseases of women; he hails from a large city in Missouri near the Kansas boundary; his general ability is widely recognized; he possesses many friends; he is a handsome man with a countenance beaming with intelligence; his likeness has appeared several times in medical journals, with his very creditable biography. (Biographies, in times gone by, were only written after a man's death; it would have been considered "bad form" to have them written up during one's life; but we live in a time of bustle and activity, and the biographies of great and future great men must be published during their lives; this may be observed daily in the medical journals and newspapers. It has now become a custom, so it must be perfectly legitimate and correct; very well, let us be informed about each other; it is extremely beneficial to look at the pictures of those whom one knows, and to

study the physiognomy of those whom we know only by reputation. It is not done as an advertisement, but merely for scientific study.)

To return to our subject. This ambitious and deserving gentleman was anxious to fill the chair of president of the association, an honor of which to be proud. To be brief, with the assistance of his St. Louis admirers (among whom was the surgeon who prints his name upon the wrappers of his reprints), the M. D. was unanimously elected, and received the congratulations and good-will of his friends everywhere.

One year later, the State Medical Association convened at S., the public invited. According to the time-honored custom, the president was required to deliver an address upon some subject connected with medical sciences; everybody expected something original and unique; I had the misfortune to be absent from this address, nor have I since seen a full publi-



Edw. Borck.

cation of it; however, I feel confident that the members enjoyed a fine scientific production, a new discovery, or the solving of some heretofore obscure problem; in any case, it must have been a monumental address as far as science is concerned. Here is an extract from the president's address, given in some medical journal:

"The president, Dr. ———, gave many valuable points in regard to the code, viz.: When a member causes to be printed upon the outside wrapper in which he sends his reprints, 'Synopsis of One Hundred Ovari-otomies,' with his name in full, etc.—in disregard of the code!!!" Hold on, the code does not say a word about wrappers.

The greatest geniuses have made mistakes; even nature makes mistakes; and such an uncalled-for and unnecessary hypercriticism is surely a mistake. It looks unkind and brings no benefit to the speaker, at the same time doing no harm to the one attacked.

The above extract hypnotized nearly every one, producing no end of laughter, but it also detracted considerably from the brilliancy of the scientific part, of which even the reporters and interviewers lost sight. All was "wrappers" and "one hundred," and "wrappers" again and again.

The majority recognized the author of "one hundred;" they knew he had discontinued his hospital several years ago, and given up the greater part of his practice; he was now devoting considerable of his time and money in giving his experience of over forty years for the benefit of the medical profession; he needs no advertising.

I have since learned that there was one crank who had never read the code, but knew all about it and desired to have that part of the president's address referred to the State Board of Health for investigation and action.

Every one is entitled to his own opinion, but it is to be regretted that the president did not give what (in *his* opinion) constituted legitimate advertising, for the benefit of the younger and the enlightenment of the older members of the profession; and why should he have selected "Ovarian Tumors" from among so many other titles, is shrouded in impenetrable mystery. Perhaps it was a token of gratitude for favors received, or a mistake in name and person.

This should come under the head of "Chronic Kickers." I often ponder over the grievances of some doctors, and the effect produced when they are communicated to others.

Let us see what effect the grievance of the president had upon some members of the profession who send out reprints. I have since received a reprint from the south folded once and enclosed in a United States wrapper, which covered two-thirds of the pamphlet; upon the uncovered space was printed the author's name, address and title of the paper; in fact, this small space was the *only* title page to be seen; I have also received a similar one from the east; from near home I have received a reprint, guiltless of any wrapper, not folded, with a one-cent stamp and my address upon the title page, together with the author's name and titles and "one thousand cases of," etc., etc.

One on the tobacco habit and one on neurasthenia in the same style; all from physicians well known; is it done to save time or money, or for the edification of the letter-carrier, or the servant who receives it? I think not; it appears to me as a lack of thought and judgment; further I will not express myself.

REPRINTS.

Reprints are perfectly proper, if used in the right way and direction. I have received hundreds of them, many of which I value highly, and preserve to peruse again at my leisure; but the fact remains that they are overdone, and employed too frequently as a medium for advertising; observe how many are printed on cheap paper, with no title or cover page. "Cheap John," both out and inside. They do not disturb me; whether they are legitimate or not, I leave to the decision of some president.

In conclusion, allow me to say, if a *reprint* is worth anything, especially when illustrated with first-class cuts, it is worth being printed on good paper, and in an attractive form, with a cover and title page; it also deserves a good wrapper to protect it, upon which the name of the author

and title of the paper should appear, to prevent the pamphlet from being buried in the waste-basket. Be systematic and get out your reprints in a form which will call attention to them and they will find recognition, like those of the *St. Louis Surgeon*.

In my younger days biographies, reprints, specialists, and many other things were not in demand; circumstances did not require them; but in the progress and improvement of the world's machinery, time and custom have changed.

There is nothing perfect in the world; do not try to please everybody; be progressive, *think more and talk less*.

4112 North Grand Avenue.

CAMPHO-PHENIQUE vs. IODOFORM.

Reprint from the *Medical Mirror*, by A. C. BERNAYS, A. M., M. D., M. R. C. S.,
Professor of Anatomy and Clinical Surgery, St. Louis College of Physicians
and Surgeons.

It is not the purpose of this paper to discuss the value of the two drugs in a general way, but merely to call the attention of the profession to a certain practical point wherein the author has found **Campho-Phenique** superior to iodoform. The many defects that have recently been pointed out accompanying the use of iodoform are so well known to all that I need not recount them. I will mention that the hopes which were originally entertained by many in regard to a certain mysterious constitutional action of the iodoform in tubercular and syphilitic diseases have been entirely dissipated by long and careful experimentation with that chemical. The fact that the use of iodoform in most of the European and American hospitals has decreased largely during the past five years, is apparent to all observers.

When **Campho-Phenique** was first shown to me, and I was told that it consisted of fifty-one parts of pure carbolic acid and forty-nine of camphor, and that it was non-irritant and could be used on mucous surfaces—for instance, on the tongue—in its pure state without causing pain, I was very skeptical. A few tests made on my own person soon convinced me that the preparation was in many respects unique, and I began to use it in superficial wounds and minor operations as a dressing. The powerful antiseptic effect of the **Campho-Phenique**, knowing its composition, required no special proof, since the antiseptic powers of carbolic acid in much weaker solutions have been demonstrated beyond error. The fact, however, that a fifty per cent solution of carbolic acid could be employed on the skin and on wounds without caustic and escharotic effects was a striking and remarkable one, knowing that this strength of a watery and glycerine solution of the same substance caused unbearable burning pain and destruction of tissues.

The tendency of modern surgery has been towards the discovery of methods of wound treatment by means of which the healing process may take with as little disturbance to the diseased part as possible. Thus the *Dauerverband* of the Germans came into use, their object being to achieve

a complete cure of the wound under a single antiseptic dressing which could be left alone for weeks and months, if necessary, without being changed. It is in this kind of dressings *a demeure* (permanent or lasting dressings) where antiseptics have their stronghold and are not likely to become obsolete. Aseptic operations and dressings, which are our ideal of good surgical practice, and which have largely supplanted antiseptic operations and dressings during the past two years, can never supplant antiseptics in the *Dauerverband*, because an originally aseptic dressing is not likely to remain so for weeks or months. The secretions will sooner or later become infected by bacteria of some kind from without. This kind of an infection will make a redressing necessary, if only on account of the vile smell caused by decomposition of the wound discharges. By the term infection an entirely harmless process may be meant, because the bacteria causing it may be simply saprophytes. I have frequently removed dressings from cases of compound fractures that had been in place for eight or ten weeks, and have found the gauze and cotton under the plaster of paris perfectly putrid, saturated with foul wound secretions and sweat, and yet have been able to demonstrate the absence of pathogenic germs.

It was my custom for several months to treat all wounds with a superficial dressing of iodoform, either in the form of a powder dusted thereon or a coat of the ethereal solution. This practice is the one which, I think, should be given up and be supplanted by the **Campho-Phenique** dressing. I unhesitatingly recommend the use of **Campho-Phenique** as a finishing dressing over all sutured wounds. The best way to employ it is to saturate some layers of gauze with the pure **Campho-Phenique** and accurately cover the incision with it. During the operation carbolic acid, bichloride of mercury, boric acid, salicylic acid, or any of the usual dilute solutions, may have been used to wash and irrigate the wound. As a final dressing, however, one which may be left alone longer than any other known to me, possessing more powerful germicidal qualities which are not readily lost by evaporation, the gauze or cotton or lint moistened with **Campho-Phenique** is superior to anything I have ever tried.

It is non-irritant, in fact causes decided anæsthesia of the skin, is powerfully antiseptic, will not dry rapidly and adheres to the skin.

Since **Campho-Phenique** is not miscible with water, it must be used pure or mixed with oil. I have generally used in its pure state, but have often for purposes of drainage used the wick saturated with **Campho-Phenique** and oil, equal parts.

I have used **Campho-Phenique** in the manner described only, and desire to emphasize this point. Over the **Campho-Phenique**, which lies next to the skin, any kind of antiseptic gauze, cotton and bandages that may suit the wants of the case may be applied, and the dressing may be left untouched, *cæteris paribus*, longer than any other I have ever tried.



Anomalies and Curiosities of Medicine. Being an Encyclopedic Collection of Rare and Extraordinary Cases, and of the Most Striking Instances of Abnormality in all Branches of Medicine and Surgery, derived from an Exhaustive Research of Medical Literature from its Origin to the Present Day, Abstracted, Classified, Annotated, and Indexed By GEORGE M. GOULD, A. M., M. D., and WALTER L. PYLE, A. M., M. D. Imperial octavo, 968 pages, with 295 Illustrations in the Text, and 12 Half-tone and Colored Plates. Philadelphia: W. B. Saunders, 925 Walnut street; 1897. Prices: Cloth, \$6.00 net; Half Morocco, \$7.00 net. *Sold only by subscription.*

Among the many medical books of the decade, this one is unique. It is positively refreshing to get hold of a work out of the ordinary, humdrum, technical, and overdone line of medical literature. To many physicians this book will be a revelation; but the attentive student of the history of the profession will meet many familiar faces anew, and he, perhaps, will treasure the work more than the pronouncedly practical physician. However, there is probably no man in the profession who will not feel well paid for investing in this anomalous book.

The table of contents includes the following: Genetic Anomalies; Prenatal Anomalies; Obstetric Anomalies; Prolificity; Major Terata; Minor Terata; Anomalies of Stature, Size and Development; Longevity; Physiologic and Functional Anomalies; Surgical Anomalies of the Head and Neck; Surgical Anomalies of the Extremities; Surgical Anomalies of the Thorax and Abdomen; Surgical Anomalies of the Genito-Urinary System; Miscellaneous Surgical Anomalies; Anomalous Types and Instances of Disease; Anomalous Skin Diseases; Anomalous Nervous and Mental Diseases; and Historic Epidemics.

Every chapter is filled with rare and curious observations. A few sentences from the preface are so much in accord with our own views that we venture to quote them: "It is noteworthy that in old-time medical literature, sadly and unjustly neglected in our rage for the new, should so often be found parallels of our most wonderful and peculiar modern cases. We wish, also, to enter a mild protest against the modern egotism that would set aside with a sneer as myth and fancy the testimonies and reports of philosophers and physicians, only because they lived hundreds of years ago."

We have not the space to give a satisfactory review of this remarkable and useful volume. We cannot close our remarks, however, without expressing the hope that the readers of the book will not judge of Ambrose Paré, the Father of French Surgery, by the ideas he held of monsters and prodigies. Some illustrations have been reproduced by Drs. Gould and Pyle from Paré's original treatise. This old hero knew surgery better than teratology.

A Text-Book of Ophthalmology. By JOHN W. WRIGHT, A. M., M. D., Professor of Ophthalmology and Clinical Ophthalmology in the Ohio Medical University. Octavo, pp. 13 405. Columbus: J. L. Trauger; 1896.

The object of this treatise is to provide the medical student with a systematic text in ophthalmology. The author has succeeded in producing a book of great value. Its arrangement is logical. We find that 48 pages are given to the anatomy of the organ; then follows a chapter on diseases of the orbit. This is succeeded by chapters devoted to the diseases of the lids, conjunctiva, cornea, etc. The text is clear, concise and well adapted to the student's use. One of the most valuable parts of the book is the glossary, which comprises over 30 pages.

We are surprised to find some omissions: for example, under the head of mydriatics, nothing is said of scopolamine, unless the author considers hyoscine identical with it; we fail to find mention of formalin, which is now considered one of our most valuable antiseptics.

We are glad to note that the author pronounces against the use of strong caustics.

Wright's operation for cataract is worthy of consideration. The incision is made at about the same part of the cornea as in Lebrun's, or the Belgian method. Dr. Wright then delivers the lens and capsule together, if possible; otherwise the cystotomy is made, and the delivery is made by pressure and counter-pressure with the fingers. We know that this is a favorite method of delivery with some operators, yet we think it should not be used, by reason of danger of infection, particularly where, as in Dr. Wright's practice, the thumb is placed directly upon the eyeball to make the counter-pressure.

There are so many good points to the author's book that we hesitate to pick flaws. We would suggest that in the second edition, the chapters on retinoscopy, ophthalmoscopy, the perimeter, etc., should be placed immediately following the anatomical description.

Pediatrics. By T. MORGAN ROTCH, M. D., Professor of Diseases of Children, Harvard University. J. B. Lippincott Co., Publishers.

In the last decade very many changes have taken place in medicine, and many of these belong especially to the department of the pediatrician.

The discovery of the extensive application of the germ theory of disease, and the introduction of serum therapy have already changed many of our views regarding etiology and treatment, and promise still greater changes in the future.

The arrangement of Dr. Rotch's New System of Pediatrics is of a practical character.

The opening chapter deals with the foetal circulation, and then follow a few chapters devoted to the infant at term and normal development. Immediately following the chapter on normal development is a section devoted to the hygiene of the nursery.

In this part of the work, and the same may be said of other sections, the most careful attention is paid to details. The questions of heat, light, furniture, ventilation, clothing, draughts, temperature, soap, sponges, etc., are all thoroughly considered. After exhausting the subject of nursery hygiene, the author takes up the all-important subject of infant feeding.

This section we consider one of the best in the book.

Lactation is fully treated and the various phenomena influencing it are pointed out.

Prolonged lactation is condemned, for the reason that after twelve months the mother's milk is not a food adapted to this stage of a child's digestive organs.

In regard to mixed feeding, the author states that if the mother has not milk enough he believes in supplementing it with a substitute food of some kind and not withdrawing the mother's milk entirely.

The analysis of milk and its substitutes receive careful attention, and the processes of making the artificial foods are described.

Those chapters devoted to the diseases of the new-born will be found exceedingly interesting and highly instructive.

The chapters on diseases of the skin deal with pathology to only a limited extent, but are very practical.

The diseases of the nervous system receive full consideration.

In his article on diphtheria the author strongly recommends the use of antitoxin.

He believes that if used early its chances for success are much greater than when used later; but he states that it is often strikingly beneficial in the later stages of the disease; at one point we cannot do better than quote his own words: "The sign by which we know the antitoxin is beneficial is the improvement in the general condition of the patient. The effect on the pseudo-membrane is characteristic. The pseudo-membrane ceases to spread, frequently whitens, shows a line of demarcation and usually within the next four days becomes detached from the mucous membrane. The temperature usually rises after the injection, but in a few days falls to normal by lysis." This description of the effects of antitoxin will be endorsed by the many physicians who have had practical experience with it.

This work contains many valuable cuts, which go to illustrate the text. The printing, binding, and paper are of the best, and speak in high terms of the publishers.

The more one reads this book the more fully does he become impressed with its intrinsic value.

H.

Compliment for Park's Surgery. Dr. Emory Lanphear, the brilliant editor of the *American Journal of Surgery and Gynecology*, says:

"The reviewer must express the extreme pleasure he has derived from the perusal of the newest 'System of Surgery'—that edited by the distinguished surgeon and author, Roswell Park, A. M., M. D., Professor of Surgery in the Medical Department of the University of Buffalo. Vol. I. has been at hand for some weeks, and has been a rather constant companion until the principal chapters have been read. As a result of this careful reading the conclusion is reached that it is by far the most carefully-written and ably-edited work yet produced in America upon the subjects pertaining to general surgery. The chapters by Professor Parks deserve particular praise as the most concise and strictly modern essays yet given to the surgeon. Other contributions are by such men as Mudd, of St. Louis; Belfield, of Chicago; Nancrede, of Ann Arbor; Ransohoff, of Cincinnati; Souchon, of New Orleans, and Eve, of Nashville; and are well prepared—though some are not as complete in detail as could be wished. The work is published by Lea Brothers & Co., Philadelphia, at \$9.00 for the two volumes in cloth; \$11.00 in leather. Vol. II. is devoted to special surgery.


 IN THE PROFESSIONAL EYE

FEW of the younger members of the medical profession of the Mississippi Valley are so well and favorably known as Doctor A. H. Cordier, of Kansas City, President of the Tri-State Medical Society of Iowa, Illinois and Missouri. Doctor Cordier is from a good Kentucky family and first saw daylight in Christian County in the year 1859. Twenty-two years later he graduated from the Medical Department of the University of Louis-



DR. A. H. CORDIER, OF KANSAS CITY, PRESIDENT OF THE TRI-STATE MEDICAL SOCIETY.

ville, receiving a certificate of honor for his high standing. For several years the doctor practiced in McPherson, Kansas, and in 1884 graduated from Bellevue Hospital Medical College. He also filled an unexpired term as house-surgeon to Bellevue Hospital. Not satisfied with these laurels, Doctor Cordier determined to add to his surgical knowledge and in 1891 and 1892 was a private pupil of Doctor Joseph Price, the renowned abdominal surgeon of Philadelphia.

Doctor Cordier located in Kansas City five years ago and has enjoyed an unusually large and lucrative practice. He has been honored by many medical societies, and, to crown all, the Tri-State Medical Society made Doctor Cordier its President in 1896.

As an operator the doctor has few equals; as a teacher of abdominal surgery he is the pride of the Kansas City Medical College, and as a friend he is the impersonation of loyalty.

PROGRAM OF THE FIFTH ANNUAL MEETING
OF THE
TRI-STATE MEDICAL SOCIETY,
OF

Iowa, Illinois and Missouri,

TO BE HELD IN

ST. LOUIS, MO., APRIL 6th, 7th & 8th, 1897.

*The Sessions of the Society will be held in the Fraternal Building,
N. W. Cor. Eleventh and Franklin Avenue.*

APRIL 6TH—MORNING SESSION—10.00 A. M.

Call to order by Chairman Committee of Arrangements.

Address of welcome.

Response.

Reports of officers and committees.

Applications for membership.

APRIL 6TH—AFTERNOON SESSION—1.30 P. M.

Dr. J. W. Fowler, Dubuque, "The Cause and Treatment of Epilepsy."

Dr. E. J. Senn, Chicago, "Gonorrhœal Synovitis."

Dr. Robt. O. Cross, Kansas City, "The Treatment of Pulmonary Tuberculosis by the Hypodermic Method."

Dr. H. H. Vinke, St. Charles, Mo., "Presentation of a Cretin—Remarks on Treatment with Thyroid Extract."

Dr. A. C. Klebs, Citronville, Ala., "The Necessity of Special Institutions for the Treatment of Pulmonary Tuberculosis."

Dr. J. K. Bauduy, St. Louis, "Unconscious Cerebration."

Dr. W. Scheppegrell, New Orleans, "The Collapse of the Nasal Alæ as an Etiological Factor in Diseases of the Respiratory Passages."

Dr. O. Beverly Campbell, St. Joseph, "A Plea for the Early Recognition and Operative Treatment of Cancer of the Uterus."

Dr. C. E. Ruth, Keokuk, "Talipes Equino-Varus, Surgery of."

APRIL 6TH—EVENING SESSION—8.00 P. M.

President's address.

Dr. J. M. Allen, Liberty, Mo., "Serum Therapy, with Report of Cases."

Dr. F. B. Dorsey, Keokuk, Ia., "Ventrofixation of the Uterus—Report of Cases."

Dr. F. Reder, Hannibal, "Lumbago."

Dr. Paul Paquin, St. Louis, subject unannounced.

APRIL 7TH—MORNING SESSION.

At City Hospital, Seventeenth and Pine streets.

9.00 A. M.—Medical Clinic, Dr. Jas. T. Whittaker, Cincinnati.

10.30 A. M.—Surgical Clinic, Dr. Joseph Price, Philadelphia.

APRIL 7TH—AFTERNOON SESSION—1.30 P. M.

Dr. W. F. Waugh, Chicago, "Some Phases of Narcomania."

Dr. Thos. H. Manley, New York, "The Morbid Anatomy of Inflammatory and Degenerative Diseases of the Peripheral Veins."

Dr. Carl Theodor Gramm, Chicago, "The Mouths of our School-Children."

Dr. Allen Staples, Dubuque, "Some Clinical Notes on Vaginismus."

Dr. Charles W. Purdy, Chicago, "The Management of Chronic Bright's Disease."

Dr. J. M. Black, Knoxville, "Surgery of the Gall-Bladder, with Report of Cases."

Dr. Donald Macrae, Jr., Council Bluffs, Ia., "Report of a Case of Echinococcus of the Liver, with Rupture of Gall-Bladder."

Dr. R. E. Farris, Anna, Ill., "Malpositions of the Uterus and Ovaries; Their Influence in Functional Disorders of the Heart and Digestive Organs."

Dr. J. A. Close, St. Louis, "Urinalysis."

Dr. Emory Lanphear, St. Louis, "Treatment of Septicemia by Subcutaneous Medication."

Dr. John Puntun, Kansas City, "The Relation of the Science of Medicine to Public School Education."

Dr. S. S. Davis, Fulton, Mo., "La Grippe and Its Sequelæ."

Dr. Wm. Porter, St. Louis, "An Additional Means of Diagnosing Aneurism of the Thoracic Aorta."

Dr. David Lieberthal, Chicago, "About the Treatment of Skin Diseases."

Dr. Ohmann-Dumesnil, St. Louis, "Presentation of a Case of Addison's Disease."

APRIL 7TH—EVENING SESSION—8 P. M.

SMOKER.

Dr. G. Frank Lydston will entertain the Society on the evening of the 7th with "An Original Doctor's Story, with Plenty of Points."

APRIL 8TH—MORNING SESSION, AT CITY HOSPITAL.

9 A. M.—Ophthalmic Clinic, Dr. Dudley S. Reynolds, Louisville, Ky.

Dr. J. Mount Bleyer, New York, will Demonstrate the Use of the Fluoroscope in Diseases of the Lungs.

Dr. Fenton B. Turck, Chicago, will read a paper on "Olegocythæmia and Leucocytosis in Gastro-Intestinal Diseases, with Methods of Treatment." Demonstrations.

Prof. Edwin Klebs, Chicago, will give a pathological demonstration.

APRIL 8TH—AFTERNOON SESSION—2 P. M.

Dr. Wellington Adams, St. Louis, "A New and Practical Method of Opening and Dilating the Eustachian Tube."

Dr. J. R. Pennington, Chicago, "The Necessity for a More Careful Examination of the Rectum in Chronic Diseases."

Dr. J. C. Spohn, St. Louis, "Lymphadenoma; Its Differential Diagnosis and Treatment Illustrated by the Report of Two Cases."

Dr. H. C. Finch, Lynnville, Iowa, "Convulsions Following Labor" (remote).

Dr. G. F. Hulbert, St. Louis, "The Treatment of the Stump in Hysterectomy and Hystero-Myomectomy."

Dr. J. Block, Kansas City, subject unannounced.

Dr. H. C. Dalton, St. Louis, "A Case of Strangulated Inguinal Hernia—Resection of Intestine—Recovery."

Dr. D. C. Brockman, Ottumwa, "Pancreatic Cysts."

Dr. G. Wiley Broome, St. Louis, "The Pathology of Malignant Disease."

Dr. J. O. DeCourcy, St. Libory, Ill., "Malaria."

Dr. E. H. McCullers, St. Louis, "Certain Morphological Characteristics of Nervous Prostration, and Their Treatment by Mechanico-Therapeutics."

Dr. G. M. Phillips, St. Louis, "Physiological Copulation."

Dr. S. G. Gant, Kansas City, subject unannounced.

Dr. James Moores Ball, St. Louis, "Traumatic Cataract."

Report of Treasurer.

Election of Officers.

Selection of place of meeting.

Adjournment.

MEDICAL PROGRESS.

A New Method of Wound Treatment.—Some time ago we called attention to the fact that Dr. C. L. Schleich, of Berlin, to whom surgery is indebted for a number of ingenious discoveries—notably infiltration anæsthesia—had introduced a new antiseptic dressing for wounds which promised to be a valuable acquisition to the resources of the surgeon. Glutol, as the new compound has since been called, is a whitish, granular powder, odorless, non-irritating and non-toxic, which is formed by dissolving gelatine in water and drying the solution in the vapors of formaline. The advantages claimed for it were that when applied to the surface of a wound the gelatine is slowly absorbed, with the continuous liberation of a small amount of formaline—a powerful, yet innocuous antiseptic. Despite the short time that has elapsed since the introduction of glutol, it has been submitted to extensive experimentation, and the high claims of its value made by Schleich have been fully corroborated. From the numerous reports that have appeared on the new antiseptic we select that of Dr. H. F. Hoyt, Chief Surgeon Great Northern & Chicago, Burlington & Northern Railways, as well illustrating its utility in general surgical practice. It is his custom to employ it as follows: After sterilizing with either bichloride, boric acid, permanganate of potash, peroxide of hydrogen, as the contingency of the case may require, he irrigates the wound with sterilized water, drying the

CONTINUED ON ADVERTISING PAGE XXIII.

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., APRIL, 1897.

No. 4.

ORIGINAL ARTICLES.

REMARKS ON CHOLEDOCHOLITHOTOMY, WITH A REPORT OF FIVE CASES.*

By ALEXANDER HUGH FERGUSON, M. D., of Chicago.

ON the 26th of October, 1889, Henry O. Marcy, of Boston, incised the ductus communis choledochus and removed from it a rough stone the size of a grape, which he had failed to crush. This appears to have been the first choledocholithotomy performed in this country. The patient made a rapid recovery. Kuemmel did the operation in 1884. Thornton published three cases in 1889. In 1890 Courvoisier had three brilliant successes. He was the first to deliberately plan the operation. The literature does not yet show 100 cases.

CONCLUSIONS.—1. For the treatment of stone in the common duct, whether impacted or loose, which cannot be extracted through the cystic duct and gall bladder, choledocholithotomy is the ideal surgical procedure. Breaking up the stone with needles or forceps is (*a*) uncertain that complete work was done, the debris may not all escape with the bile, and more or less injury (puncture or bruise) is done to the walls of the duct; and (*b*) less opportunity is afforded to test the permeability of the duct, for it may be obstructed lower down.

*Abstract of a paper read before the Tri-State Medical Society of Iowa, Illinois and Missouri, at St. Louis, April 6, 1897.

2. Cutting into the duct longitudinally does not appear to predispose to complications or sequelæ.

3. In the majority of gall stone cases, causing obstruction of the common duct, there are also stones in the cystic duct and gall bladder, then cholecystostomy should be the operation of choice, because (*a*) it is usually easy to remove stones from the common duct through the dilated cystic duct; (*b*) the safety of the patient from death by cholemia is insured and the patient may not stand any more; and (*c*) should a stone be left in the common duct it can be treated afterwards by bougieing the ducts or by choledocholithotomy in preference to cholecystenterostomy.

4. The diagnosis of occlusion to the ductus choledochus is not difficult in the majority of cases; the chief clinical features being (1) the history of cholelithiasis. (2) Pain (*a*) referred, (*b*) local, over the common duct. (3) Tenderness elicited by finger-tip pressure is not over the fundus of the gall bladder unless it, too, contains stones, or is inflamed. (4) Jaundice is the sign of an obstructed common duct; chronic exacerbating jaundice is more characteristic of obstruction by a gall stone loose in the duct, than anything else. (5) Area of gall bladder dullness lessened in chronic cases and increased in acute obstruction in a case that has had manifestations of cholelithiasis for a short time. I feel convinced that in every case of biliary colic the gall bladder enlarges during the first attacks. (6) Several slight attacks within a day or week, coupled with icterus, is strong evidence of choledochus stone. (7) Vomiting may or may not be present; nausea usually is. (8) Emaciation is a late sign of this trouble. It was only well marked in one of my cases. (9) Chills and fever in 25 per cent. of cases (Courvoisier). Pyrexia was present in four of my cases.

5. *Technique of Choledocholithotomy.* (1) Incision oblique when the gall bladder is contracted. (2) Adhesions should be carefully separated in the line of search for stones and nowhere else. The fundus of the gall bladder being found, it is followed on the under surface of this organ to the cystic and common ducts. The adhesions are cautiously cleared away along this route, but any that may be shutting off the general peritoneal cavity should be left alone. When the foramen of Winslow is reached the gastro-hepatic omentum is palpated, for in it courses the ductus choledochus. If the adhesions are dealt with as above described, the subsequent drainage is easier and more efficient. (3) Incision of the duct is done longitudinally over the interior surface of the stone. (4) Test the patency of duct by probe or water test. (5) Suturing the duct, is in my opinion, not at all essential for success, and may be harmful by (*a*) prolonging the operation, and (*b*) by injuring the wall of a pathological duct that does not hold sutures. (6) Drainage, both tube and gauze, should be used.

Doctor Ohmann-Dumesnil.—The interesting articles by this noted dermatologist have attracted great attention during the last year. They will be continued in the issues of the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER, and will be found in every issue for many months to come. Doctor Dumesnil has probably contributed more lectures to international clinics than any other American. He has recently resigned the Chair of Dermatology and Syphilology in the Marion-Sims College of Medicine, in order to have more time to devote to his practice.

CREOSOTE CARBONATE (CREOSOTAL) AND GUAIACOL CARBONATE (DUOTAL).

By H. P. WELLS, M. D., of St. Louis.

MODERN chemistry seems to have kept pace with the rapid advancement made in medicine in the last decades. The pathologists and bacteriologists have given us clearer insight into the specific causes of infectious diseases, and the chemist, with admirable promptness, has followed their achievements by giving us more adequate and direct means of combating these causes.

Since the almost universal acceptance of the etiologic role played by germs in infectious diseases, the compounds and synthetic products of the phenols have held first place among germicidal agents. Outside the body their effect on bacterial life is marked, as shown by experiment; and in the gastro-intestinal canal it is in every respect the same. During absorption, however, they unite with the available albumins, especially the tox-albumins, forming non-antiseptic compounds which have no further effect on bacteria.

These compounds of tox-albumins with the phenols, are, probably, non-toxic. In this form they rapidly undergo oxidation in their passage with the blood current through the system, and are promptly eliminated in the urine as ethereal sulphates. Hence, the phenols not only destroy directly disease germs in the intestinal tract, and neutralize the poisons formed there, but after their absorption they effect the elimination of tox-albumins from the system by combining with them.

This remarkable group contains many compounds, but most of them have disadvantages that seriously interfere with their employment. They have an intensely burning taste and are caustic when concentrated, so that their use, in quantities sufficiently large to exert their peculiar antiseptic action in the body, has heretofore been impractical.

Chemistry has recently succeeded, however, in combining the phenols with other substances so as to render them non-irritating, without, in the least, impairing their germicidal powers. This is done by combining organic acids, such as salicylic, benzoic, and carbonic acid with the phenol radical. It is the latter acid that has been made use of in the preparation of the carbonates of creosote and guaiacol. These phenol carbonates may be called non-toxic poisons, on account of the comparatively large doses which may be given without ill effect.

The maximum amount of free phenol that can be given with safety is from 6 to 8 grains, while the carbonates of creosote and guaiacol may be taken in drachm doses. They are neutral, non-caustic, and non-irritating, and have almost no taste or smell. Unlike the other phenols, they pass through the healthy stomach unchanged. But if fermentative action is going on in the stomach, small quantities of phenol are separated, which stop the process.

After entering the intestines the phenol carbonates are broken up into their powerful constituents, creosote and guaiacol and carbonic acid.

While the decomposition of salol and other of the phenols occurs at the commencement of the intestinal tract, that of guaiacol and creosote carbonate takes place along the whole of the duodenum, jejunum and ileum. At the commencement of the large intestine it can no longer be found. This last fact suggests their use in cases requiring antiseptic action throughout the small intestines, as in typhoid fever.

One of the principal objections to the use of the ordinary beechwood creosote and liquid guaiacol is its detrimental action on the stomach, due to its causticity. At the last Congress of Tuberculosis at Paris, Professor Hayem noted that dyspepsia is frequent in tuberculous patients, and that most, if not all, of this dyspepsia is caused by the drugs administered, especially creosote.

Even gross lesions of the stomach have been found, ulcerations where a creosote capsule had ruptured.

By the introduction of the carbonates of these drugs as a substitute for the crude form, Dr. Von Heyden's successors at Rodsbuel, near Dresden, Germany, placed at the disposal of the profession a non-irritant, non-poisonous preparation, containing respectively 92 per cent. of the pure stercosote, and 91 per cent. of guaiacol, chemically combined with carbonic acid. They are borne well in very large doses by even vulnerable stomachs, so that the maximum of benefit may be derived from their use in cases of pulmonary phthisis.

The tolerance displayed by these two carbonates depends, first, upon the absence of caustic and poisonous properties; second, the absence of the intensely nauseous taste and odor of creosote; and, last, the fact that absorption takes place, not in the stomach, but throughout the intestines.

Professor Dujardin Beaumetz, of Paris, in the *Dictionnaire de Thérapeutique*, 1895, says:

“Creosote is recognized as the most efficient agent in the treatment of tuberculosis; but, being caustic, it can only be given in small doses. This objection does not hold with creosotal. The creosote is in such combination that doses formerly believed impossible can be given with impunity. Hence, its employment constitutes a most important advance in the treatment of tuberculosis.”

Phthisis pulmonalis will naturally be the malady in which creosotal will find its commonest application. But it is useful also in visceral tuberculosis; such as of the pleura, the peritoneum, and the meninges. In the so-called surgical tubercloses, white swelling, Pott's disease, tubercular gummata, ostitis, cold, abscess, adenitis, etc., creosote carbonate may be given, often with marked effect, local treatment, of course, being not neglected. In the idiopathic anæmia of young girls; in chronic bronchitis; in tubercular abscesses and fistulæ, both locally and internally; and in a number of skin diseases; with the best results from its use in impetigo and aphthæ. Four or five inunctions should be made of the diseased area daily.

To those few patients to whom the mild taste of creosotal is objectionable, the tasteless and odorless guaiacol carbonate may be administered. It is also advisable to change off from time to time between creosotal and guaiacol carbonate.

The dose of these preparations varies with age and the severity of the disease. For children, 15 to 90 grains daily. Adults can take from 1 to

4 drachms daily. These are not maximum doses, and may be still further increased. When used hypodermically, the solution should be pure and slightly warmed.

The happy results obtained from these preparations are due, not entirely to the absence of poisonous by-effects, but also, as above stated, to the fact that absorption takes place, not in the stomach, but in the intestines, and it is so slow that the entire organism is kept continuously under the influence of the drug.

THE CAUSES AND TREATMENT OF EPILEPSY.*

By J. W. FOWLER, M. D., of Dubuque, Iowa.

THE most peculiar and least understood disease of the nervous system to-day, is epilepsy. It is the oldest disease of which we have any authentic record. We find records of it in the very oldest Greek writings, and later it is mentioned in the New Testament. Though its peculiarities have been written about for centuries past, we are not as yet positive of its true nature. It is characterized by momentary unconsciousness, without the least indication of a spasm, to the more severe morbid phenomena of a paroxysmal nervous explosion. With these abnormal phenomena we have psychical elements in the mental operations, and physical elements are seen in motor disturbances. The older writers classified this disease into two divisions. These were, with their several different stages: "epilepsia gravior" and "epilepsia mitior," or, as often expressed in French, "haut-mal" and "petit-mal." Modern science recognizes and describes several divisions and irregular forms of epilepsy, but, as only the causes and treatment of idiopathic epilepsy will be touched upon, the description and symptoms of the various divisions and classified forms, from the more familiar types to the masked and various irregular varieties, with all their different stages, will be passed over. It is universally admitted that the pathological nature of epilepsy is clouded in obscurity. Authors have not arrived at positive conclusions on this subject. True, different organs have been found to be affected, but these lesions are only "supposed to exert an influence in the production of the disease." These lesions have been sought for in the brain, spinal cord and other parts of the nervous system.

Some of the conditions which are said to have been discovered, and are supposed to have an influence upon the production of the epileptic phenomena, are: "Considerable dialation of the vessels of the medulla oblongata," "unsymmetrical development of the olivary bodies," "asymmetry of the medulla," "constriction of the spinal cord, with secondary atrophy of the medulla," "indurations both in white and gray matter," "disorganization of the nerve element of the medulla," "osseous growths pressing upon nerve centers," "spicula of bone penetrating the brain," "cysts," "vascular anomalies," "tubercular deposits," "softening of

*Read before the Tri-State Medical Society of Iowa, Illinois and Missouri, at St. Louis, April 7th, 1897.

brain substance," "lesions of the cord and certain spinal nerves," "changes in the contour of the skull," "thickened and calcareous meninges," "increase of the weight of the brain," "diminution in its weight," "tumors of the cortex," "irregular distribution of gray matter," "fatty changes in the vessels," "atrophy of the cells in the brain," "thrombosis," "obliteration of vessels and sinuses," "and still other changes have been found." But in other cases, the same or similar conditions have been found. There are more speculative theories than demonstrated facts, and the pathology of epilepsy is surrounded with so much obscurity, that it gives one practically no clew to any of the causes of this disease. There are at times conditions which, when magnified, are *exciting causes* of epilepsy, especially when the epileptic constitution exists. Of some of these conditions I wish to speak. According to Rosenthal, Brown-Sequard, Hare, Hamilton and others, by far the greatest number of cases begin between the ages of ten and twenty years. This is the period of reflex irritations. Irritations of the bladder and the sexual system, especially phymosis and adhesions of the prepuce. Difficult dentition and undigested food. Ovarian irritations, the commencement of the menstrual function and the suppression of the vaginal fluxes. Exanthemata, peripheral lesions involving the nerves, intestinal worms; and especially irritations in the alimentary canal, and the absorption into the blood of toxic germs.

But similar injuries and lesions are found in subjects who do not have epilepsy; and all irritations, both central, peripheral or reflex, do not always produce this disease. The formation of an epileptic constitution and the existence of this disease in a subject, undoubtedly depends primarily upon an instability of the nerve elements of the cortex cerebri, and secondarily an anæmic nerve element reproduction, throughout the nervous system, including cellular elements in both ganglia and brain substance. The explosion of nervous force producing a seizure is probably due to an exaggerated excitability of the medulla oblongata. Our patient has, we will say, an epileptic constitution. The cellular elements being in a condition of irritability, are ready to be touched off by some exciting cause, like powder by a flame or a torpedo by a spark.

WHAT NOW SHALL BE OUR COURSE OF TREATMENT?

It is not necessary to state to medical men that in all diseases there may exist complications which will render any treatment unavailing. But it is one of the faults of our profession, that often we conclude that a certain method or a particular treatment is of no avail because it fails immediately to cure. Investigations made by Kellogg, of Battle Creek, have proven that after an epileptic seizure the toxicity of the urine is double the normal quantity. Augustini has recently made investigations on the gastric juice of epileptics, and finds that when taken just before or after an attack it is laden with toxins sufficiently powerful to kill rabbits when injected into the abdomen; while the same quantity of normal gastric juice has no effect upon them. Hasty eating produces gastro-intestinal disorders. Cheese and sausage should be avoided, because laden with germs. For the same reason, oysters and all shell-fish should be prohibited. Wines and beer carry yeast germs. Meats of all kinds are stimu-

lating and assist materially in producing an over-production of normal tissue poisons. Tea, coffee and tobacco are stimulating, and in due time will weaken the action of the heart. Easily assimilated food should be selected. A strict dietary regimen of milk and well-cooked grains, a moderate quantity of baked or well-steamed potatoes, and other vegetables cooked in milk, with occasionally soft-boiled or poached eggs, is as near an aseptic dietary as can be conveniently secured. Raw peeled fruits and most cooked fruits are not only harmless but beneficial. Pure water in large quantities is a toxine modifier and especially aids the kidneys in carrying away poisons from the blood. We know that nutritious food, converted into good blood, is not a good culture ground for the microbes of any disease. Weak, nervous epileptics, must be fed and furnished with strength. The majority have a starved nervous system and a constitution with little or no power of resistance. An eliminative treatment by the alimentary canal, kidneys and skin, should be an essential part of the treatment. The general practitioner knows that a large majority of the diseases treated by him are diseases which have their origin from or are directly due to derangements of the alimentary tract. Both male and female are subjects of constipation. We know that a train of nervous symptoms comes from chronic constipation. How quickly the locking up of the bowels or even a torpid condition will produce headache and feverishness. Absorption of poisons can first be detected upon the breath. It is one of nature's methods of elimination. The blood is charged with intestinal poisons that have been absorbed in a few hours. If the person has an epileptic constitution and a store of irritable nervous force, with a heart in full sympathy, there will be a touching off with the result of a momentary unconsciousness, or a nervous explosion in the form of a nightmare, or to that more severe form of epilepsy, the seizure. I consider nothing of more importance to the system of treatment which I have adopted than an *antiseptic laxative*. By using the Woodbridge tablet, No. 2, containing podophyllin, calomel, menthol, thymol, eucalyptol and guaiacol carbonate, we have a harmless and mild laxative combined with a happy combination of unirritating antiseptics. By giving an antiseptic laxative in powder form, it is not so readily absorbed as a liquid antiseptic, and it thus continues to make aseptic the full length of the alimentary canal. This antiseptic intestinal treatment checks the activity of the toxic germs and prevents the formation of certain media suited to germ growth. It modifies the conditions which make germ culture possible. It prevents the development of toxins, the absorption of which into the system may be a spark sufficiently great to be the exciting cause of an epileptic attack.

With my general plan of treatment, I endeavor to maintain a moderate and even circulation. I have always used digitalis, three or more times a day, in moderate doses, combined with the bromide mixture. In some cases digitalis is not indicated, especially when there is constant hyperæmia of the brain or an irregular pulse. In irregular heart-beat, I find nothing equal to the fld. ext. of cactus grandiflorus, in ten to twenty drop doses three or four times a day. For quieting the irritability of the nerves in all idiopathic cases where we know there is a nervous surcharging of the cortical centers, no single drug has ever been found by experimentors or scholars of recent research equal to one of the bromides. True,

we have good medicines, like belladonna, ergot, nitro-glycerine, hyoscyamus, gelsemium, antifebrin, ammonium chloride and some others which are beneficial when combined with other medicine, but nothing as yet has been found to take the place of the bromides. The following is about the quantity of the combined bromides which I usually give:

℞ Potass. Brom.....	
Sod. Brom.....	
Ammon. Brom.....	
Potass. Iod.....	
Potass. Bicarb.....	aa ʒ ij
Tr. Digitalis.....	ʒ ij—ʒ iv
Liq. Potass. Ars.....	ʒ ij
Infus. Columbæ.....	q. s. ad. ʒ xij

Sig.: Half a tablespoonful after dinner, supper and at bed-time.

We know that in many diseases drugs in combinations produce superior results, and I am positive that in this disease the combined bromides greatly enhance the power of allaying or aborting the storm. In each dose in the above prescription the total amount of the bromides is small. In all epileptics having nocturnal attacks, they are requested to set an alarm to awaken them at 3 o'clock or thereabouts, in order that the bladder can be freed from pressure and a dose of medicine can be taken. Where chronic poisoning by the bromides is produced, and in some cases where they cannot be tolerated at all, or where, in very exceptional cases, they greatly aggravate the number of attacks, other medicines must be substituted. The hypophosphites with iron, especially the hydrocyanate of iron (Tilden) are of very great benefit where there is weak digestion and a condition of mental sluggishness. During the last three years I have prescribed hydrocyanate of iron (Tilden) in tablet form to all epileptics treated by me, and I find it not only a tonic, in the general sense of the word, but a neurotic tonic.

All cases must not be treated in a routine way. If a child is anæmic, it not only needs the small dose of arsenic, which I usually add to my prescription to allay any eruptions produced by the bromides, but it needs cod-liver oil with malt or good graham bread dipped in cream. Some cases need a larger dose of digitalis than do others. Sometimes I give the digitalis separately and require the patient to take sufficient to keep the pulse below 80 or 85. If there is a hyperæmic condition of the brain, digitalis would not be indicated. The combination of the bromides and the iodide, as given above, are increased very gradually as the time lengthens between the attacks. In severe cases the quantity of the bromides in each dose is rapidly increased until the paroxysms are controlled; then a gradual increase thereafter until a paroxysm occurs; then they are ordered a minimum dose, to be gradually increased, until another attack again occurs. In one case of a young lady 26 years old, who had terrific seizures every ten minutes for three and one-half days, I gave within six hours 160 grains of the combined bromides and $\frac{1}{2}$ drachm of tincture of digitalis. This was kept up for twenty-four hours, until the pulse became normal and a restful sleep came on. This case never had but one attack since, and that was over three years ago. She was a very thin, anæmic person. I treated her dietetically by forced feeding, the same as I do consumptives. A diet list was given her, and a small tempting lunch was taken every three hours. This was continued until

she gained fifteen pounds, when she was allowed to take a larger meal four times a day. Where brominism is produced, we can give gelsemium and cannabis indica combined. The former allays the irritation in the spinal cord, and cannabis indica quiets the excitement in the cerebrum. Quinine and the salicylates should never be given, as they have a marked tendency to increase the number of spasms. Certain surgical operations are of benefit when indicated. Castration and the removal of the ovaries are in some cases curative. Clitoridectomy, and especially circumcision and trephining, when indicated, are beneficial. But further than showing that I appreciate and am in favor of surgical operations in certain cases of this disease is not the object of this statement. In addition to the medicinal and the dietetic treatment, I insist on the patient doing regular hard work or fatiguing himself by severe exercise in the gymnasium or by walking. It is essential to a cure in most cases. A cool sponge bath is ordered each night. The patient sleeps better and the nerves become stronger by it. In all recent cases, and a very large proportion of cases of long standing, this treatment as outlined above, with its essentials and its minor factors carefully and intelligently carried out, stops the extension of a so-called incurable degenerative disease.

Improved Technique of Vaginal Ligation of the Uterine Arteries and Indications in Uterine Fibromata.—Dr. Augustin H. Goelet, in a paper presented to the New York State Medical Society (*Medical Record*), thinks that this operation has not been given the consideration it deserves as a conservative surgical measure, and that it has a distinct place in gynecological surgery.

The purpose of the operation is to produce atrophy of these tumors, by cutting off the nutrition afforded by the uterine arteries, which furnish the uterus with two-thirds of its blood supply.

The indications for the operation are interstitial fibroids, which do not reach above the level of the umbilicus, and small subperitoneal growths, which spring from the wall of the organ below the fundus, and where extensive adhesions have not formed with adjacent structures through which the tumor might receive nourishment.

He thinks that ligation of the vessels *en masse*, including the surrounding tissues at the base of the broad ligament, does not positively assure complete obliteration; that with the shrinking of the tissues, in consequence of the compression, the ligature loosens and the circulation is restored. He, therefore, clamps and ties the vessel, then divides it, tying afterwards the uterine end of the artery, which bleeds also, because of its anastomosis with the ovarian. In those cases where this method was adopted the tumor has undergone complete atrophy.

While the operation has a limited application, it possesses some advantages which commend it, viz.:

- (1) It involves little or no risk, when carefully executed.
- (2) It does not involve a tedious convalescence.
- (3) It is quickly and easily performed.
- (4) Its immediate result is to afford prompt relief of the symptoms.
- (5) Its ultimate result, which is manifest within six months, is complete, or almost complete, atrophy of the tumor.
- (6) It does not unsex, mutilate or disable the patient.

A MEMOIR ON THE ODORIFEROUS SENSE.

By J. MOUNT BLEYER, M. D., F. R. A. M. S.; of New York City.

[CONTINUED FROM FEBRUARY ISSUE.]

IN order to make this memoir as complete and intelligible as possible, in such a short space as in a magazine article, I would fain give up, nevertheless, the entire attempt to reproduce an anatomical sketch of the most important parts of the interior organ (of the nose) and its sensory accessories, upon which this paper is founded.*

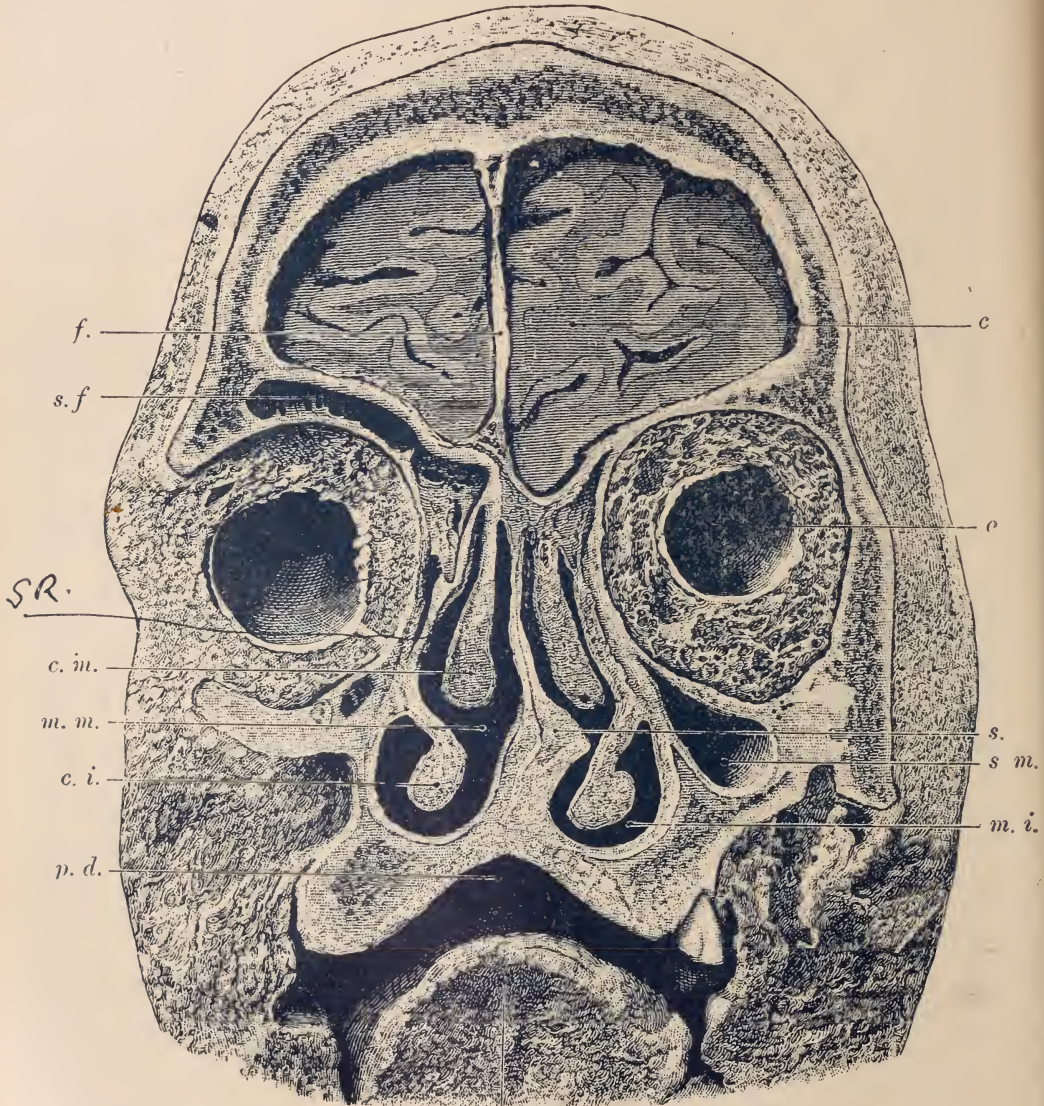


FIG. I.

*The detail descriptive gross and minute anatomy in part only, and illustrations, are taken from "Quain's Elements of Anatomy," Longmans, Green & Co., London, 1894; and Fig. I. from Dr. A. Onodi's work, of Budapest, "Die Nosenhoehle und Ihre Nebenhoehlen," Wien, 1893.

The picture of the nose before your view below, shows a cut made to lay it open through all its length from right to left, or the whole external nose cut off, so that it can be inspected without hindrance into the very inner of its cavity.

The whole nasal cavity is divided into two halves by a perpendicular partition (nasal septum marked S), extending from rear to the front. The beginning of this partition (nasal septum) is at the entrance of the nose, which is divided by it into two entrances, the right and left nasal fossæ (Mi.). The figure shows the very irregular shape of the nasal cavity, the external walls of each half forming a multitude of conspicuous projections jutting into the cavity. Three principal projections are noticed on each side, which are designated nasal shells or turbinated bodies, in consequence of their resemblance to a muscle-shell; (Ci.) inferior turbinated body; (Cm.) middle turbinated body.* In general, they form a kind of bent ledges, extending from the front to the rear, projecting into the cavity with a kind of free list, and partly supplied with secondary ledges. The figure represents these shells (Ci. and Cm.) in the cut, showing how they divide each half of the nasal cavity into layers overlying or freely communicating with each other; and, above all, how through them, their secondary projections, a considerable increase of the surface of the nostril partition is brought about. Of these two turbinated bones, the inferior is the longest, extending from the vestibule to the posterior nares. The middle turbinated, arising about a quarter of an inch farther back, terminates posteriorly on the same line as on the preceding. Both of these bones are concavo-convex, their convexity facing upward, inward, and toward the septum, while their concavity looks downward and outward to the external wall of the nose. By their superior border they are attached to the osseous walls of the nose. The superior turbinated body, or bone, is merely a plate of the lateral mass of the ethmoid bone. This so-called superior bone protrudes so slightly into the nasal fossa that it cannot be seen on the living subject, either through the anterior or posterior nares. These thin bones divide the nasal channel into three divisions, the so-called meati of the nasal fossa—Mi. being the inferior, and M. M. the middle, which are the chief nasal respiratory channels, the superior meatus (S. R.) giving passage to but little, if any, air during quick respiration, allowing quite a quantity to pass during the act of sniffing, which voluntary action is performed when one wants to obtain a decided sense of a smellable substance.†

The whole surface of the interior of the nasal fossæ, with its prominences and corresponding hollows, is lined with a soft membrane, the so-called pituitary or Schneiderian membrane, which is highly vascular and inseparably united with the periosteum and perichondrium, over which it lies. It also varies regarding its thickness and vascularity in different parts. Found thickest and most vascular over the turbinated bodies (particularly the inferior and on the septum nasi); but in the intervals between the turbinated bones, and over the floor of the nasal fossæ, it is considerably thinner. In the maxillary, frontal and sphenoidal sinuses, and in the ethmoidal cells, the lining mucous membrane is very thin and pale, and is a contrast with that which lines the fossæ.

* This illustration only shows the two turbinated bodies; the third, however, lies just above the middle.

† Any further anatomy on the bones of the nasal fossæ required to elucidate the contents of this memoir can be found in any work on anatomy.

The character of the epithelium varies in the different parts, and by this, in a general way, three regions of the nasal fossæ may be distinguished. Thus the region of the external nostrils (the vestibule) is lined with stratified squamous epithelium; and the remainder is divisible into two parts, viz., the upper or olfactory region, in which the epithelium is now ciliated and columnar; and the lower or respiratory region, in which, as also in the sinuses, it is ciliated and columnar. The membrane in the respiratory part covers the middle and inferior turbinals, and all the lower portions of the fossæ, and is studded with racemose glands, which open by orifices apparent on the surface.



FIG. II.

The olfactory mucous membrane, which lines the olfactory region or that in which the olfactory nerve is distributed, includes in man only the uppermost part of the fossæ. It is extremely vascular, its mucous membrane is covered by a very thick non-ciliated epithelium, and it is more delicate in consistence than that of the ciliated region, being indeed soft and pulpy. It is of a yellow color and extends beyond the olfactory part. There are numerous glands in that region, known as *Bowman's*. They open by fine ducts, which extend to the surface between the olfactory epithelium cells. In the mucous membrane itself the gland-tube is somewhat convoluted and enlarged, and it may have one or two branches. It is limited throughout by a basement membrane, and lined and almost filled with columnar or polyhedral secreting cells. These are of "serous" type in man. These gland-cells secrete a yellowish brown pigment. In man the gland-ducts frequently open into a small sub-epithelial receptacle lined with flattened epithelium, from which a fine tube passes to the surface between the epithelium cells.

Here and there epithelium of the surface, as shown by Max Schultze, is ciliated and not olfactory; where this is the case, the ordinary racemose glands are found. (Klein.) On the other hand, Bowman's glands are not entirely confined to the olfactory mucous membrane, but may extend a short distance beyond it into the respiratory part of the fossæ.

The columnar cells on the surface of the olfactory mucous membrane (Figure 3*a*) are prolonged at their deep extremities into a process which is generally somewhat branched towards its deeper end. The nuclei of these



FIG. III. Cells of the Olfactory Region. Highly Magnified. (M. Schultze.)

1. From the frog; 2. from man; *a*, epithelium cell, extending deeply into a ramified process; *b*, olfactory cells; *c*, their peripheral processes; *e*, their extremities, seen in 1 to be prolonged into fine hairs; *dc*, their central filaments.

cells are oval in shape and lie all at about the same level (zone of oval nuclei); i. e., in the deeper part of the columnar portion of each cell. The protoplasm of the columnar cells contains granules of yellowish-brown pigment. Amongst the branching central ends of these columnar cells there are a large number of peculiar spindle-shaped cells (Figure 3, *b*), each consisting of a large, nearly spherical, nucleus surrounded by a relatively small amount of granular protoplasm. From each cell proceeds a superficial and deep process. The superficial process (*c*) is a cylindrical or slightly tapering thread passing directly to the surface, and terminating abruptly at about the same level as the free surface of the epithelial cells, between which it lies, or a little beyond; the deep (*d*) is more slender, and passes vertically inwards. This last usually presents a beaded appearance similar to that observed in fine nerve filaments. These cells were termed by



FIG. IV. An Olfactory Cell. Human. (V. Brunn.)

a, Central process prolonged as an olfactory nerve fibril; *b*, body cell with nucleus; *p*, peripheral process toward free surface; *c*, knob-like clear termination of peripheral process; *h*, bunch of olfactory hairs.

Max Schultze olfactory cells, to distinguish them from the columnar epithelium cells, which are much fewer in number, and which are entirely surrounded with the fine rod-like peripheral processes of the smaller cells. The nucleated several rows deep, and form a layer of considerable thickness beneath the columnar cells. The olfactory (but not the columnar) cells are said to project through apertures in a cuticular lamina which bounds the mucous membrane superficially.

The peripheral process of the olfactory cell was observed by Schultze to be surrounded by a short projection (Figure 3, 2 *e*); according to V. Brunn, this appears in well-preserved specimens to be surmounted by a bunch of fine short hairlets, which are termed the olfactory hairs. (Figure 4.) Long and fine hair-like processes have long been known to exist on the olfactory

cells of amphibia, reptiles and birds. (Figure 3, 1, *e.*) On this broad basis of each single olfactory cell stands a wreath of extremely fine and tender hairs, continually shaken by a kind of lashing motion. Each little hair, in rapid motion, bends in a certain direction, assuming the shape of a hook, then raises itself, again bends as before, and so on. When we look, or observe them by a high power of the microscope, at a large row of these olfactory cellules with their numberless little lashing hairs, we have in miniature the same aspect which a waving cornfield represents. The motion is so rapid that one at first perceives only a kind of glimmering along the edge formed by the bases of the vesicles, and only when the movements under the microscope gradually slacken, the single hairs become visible and recognizable. It is on account of this phenomenon the said coating, consisting of vesicles (cellules), set with oscillating hairs, is called ciliated epithelium. Physiology has yet no explanation for this wonderful phenomenon; we entirely ignore what force, inherent in the cellules, or work-

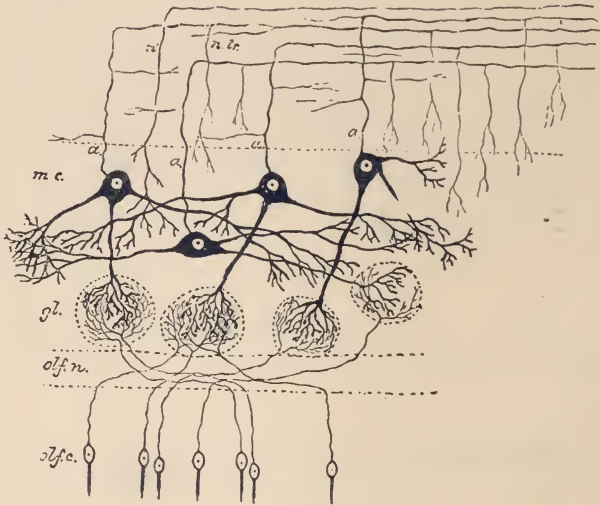


FIG. V. Diagram of the Connections of Cells and Fibers in the Olfactory Bulb.

m. c., cells of the olfactory mucous membrane; *Olf. n.*, deepest layer of the bulb, composed of the olfactory nerve fibers, which are prolonged from the olfactory cells; *gl.*, olfactory glomeruli, containing arborisations of the olfactory nerve fibers and of the dendrons of the mitral cells; *m. c.*, mitral cells, *a*, their axis-cylinder processes passing toward the nerve fiber layer; *n. f.*, of the bulb to become continuous with fibers of the olfactory tract: these axis-cylinder processes are seen to give off collaterals, some of which pass again into the deeper layers of the bulb; *n.*, a nerve fiber from the olfactory tract ramifying in the grey matter of the bulb.

ing upon the hairs from without, causes the regular rhythmic oscillations of the latter; we only know that it is a force which is rapidly extinguished on the expiration of the organism. It is true, the epithelium separated from the organism, nay, even the single entirely isolated cellule, continues to motion for awhile, but the movement soon expires before we can discover a death change in the little mechanism. Some readers may expect me to designate the motive force of the hairs as "vital force," but I beg leave incidentally to remark that this is a name and a conception long buried in the lumber chamber of the past, the resurrection of which would fill every conscientious physiologist with horror. I defer the justification of this horror to some other time, observing here that the forces which keep up the

animal organism, are no new or special ones, but the same physical and chemical forces which rule inanimate nature, and that they act in the organism according to the same inviolable laws which govern them in the outer world. But enough of digressions. Let me say a few words regarding the olfactory cells of the amphibia and fishes. In them we find the cells grouped together in the form of bud-like organs resembling the taste bulbs of the tongue.

It has been demonstrated by several observers, by the aid of the methyl-blue and silver chromate methods, that the fine varicose central processes of these cells are directly continuous with the fibers of the olfactory nerve, and terminate centrally by dendritic ramifications in the glomeruli of the olfactory bulb.

Into this minutely described membrane, lodged at first in grooves on the surface of bones of the nasal cavity, and through it in all directions, spread the tender and even microscopical hardly distinguishable fibers of the nerve of smell. The nerves of the septum (Figure 6) are rather larger than those of the outer wall of the nasal fossæ; they extend over the upper third of the septum, becoming very indistinct as they descend. The nerves of the outer wall (Figure 7) are divided into two groups—the posterior being distributed over the surface of the upper turbinated body, and the anterior over the anterior part of the olfactory groove.

[TO BE CONTINUED.]

LA GRIPPE AND ITS SEQUELÆ.*

By S. S. DAVIS, M. D., of Fulton, Mo.

IT is not my intention, in this brief paper, to go into the origin, history and treatment of la grippe, but to give you the actual experience that the general practitioner has with this disease, together with its many complications and sequelæ. Its path is a broad one: it knows neither latitude or longitude. Neither is it a respecter of persons, attacking infancy as well as the old and decrepid, though it is in the latter class of patients where it does its most deadly work. It certainly is infectious, getting into a family and attacking one after another till all have felt its iron grasp, more or less severe. When it invades a neighborhood in the fall, it remains as a pest more or less severe during the entire winter. Its spread is not very rapid, traveling only as fast as intercourse from neighbor to neighbor, or nation to nation, will permit. It pays no attention to the prevailing direction of the winds in its movements, and this adds strength to the belief of most observers that it is an infectious contagion, and not a miasmatic contagion. It has no redeeming features, like other contagious diseases, in that one attack does not preclude another. Its onset and attack in different persons is as varied as the winds. To one it comes with the degree and rapidity of a cyclone; to another it creeps on with the assiduousness of a malaria, of which, it seems to me, to be a first cousin. All agree that if you have once had it, you will never forget it.

* Read by title before the Tri-State Medical Society of Iowa, Illinois and Missouri, St. Louis, April 8, 1897.

If its victim is a sufferer of any chronic ailment, though dormant at the time, it stirs it up with all the vigor or which it is capable. My own observations, extending over a period of several years, confirm me in my belief that it is conducive to more after-effects than any other contagious disease of its class. As before stated, its onset, in any given number of cases, may all be different. A stout, robust person may be enjoying unusual good health on retiring to bed, only to wake up during the night with high fever, severe headache, darting pains through every muscle in the body, and a feeling as if he had just returned from the wood-shed in his boyhood days after a recent mutilation of his father's favorite apple-tree. When asked what hurts most, the invariable reply is: "Oh, I just hurt all over!" Sometimes it is ushered in with a severe chill, followed by a high fever, ranging from 102° to 105° F. At other times the onset is slow, the patient having a feeling of malaise, with chilly sensations for a day or two before coming for medical advice. In these cases the temperature rarely ever rises above 100° F., or there may practically be no fever at all. It is sometimes extremely difficult to diagnose these cases from an ordinary case of remittent or catarrhal fever, if the case be a sporadic one. I believe it could only be done with the aid of the microscope. The resemblance of some of these cases to a malarial infection is so accurate, which occasions my statement made before, that they seem to be first cousins. I am fully aware that a great many cases may be called and treated as grippe, during an epidemic, that bear no relation to it. But, with two or three days of careful study, in the hands of a practical observer, this should not often occur.

COMPLICATIONS AND SEQUELÆ.

In the adult, the most frequent complications are: pneumonia, pleurisy, bronchitis and a subacute form of gastritis with obstinate constipation and torpidity of the liver. In children, I believe the most frequent complications are: broncho-pneumonia, bronchitis and otitis. I have met with one or two cases of a peculiar skin eruption, resembling measles very much, even to breaking out in the roof of the mouth. This eruption only lasts from twenty-four to forty-eight hours, and disappears without desquamation or other evidence of the specific eruptive diseases. In one case I made a diagnosis of measles, but on my second visit was compelled to tell the parents I was mistaken, after the whole neighborhood had quarantined themselves against this house. Pericarditis, endocarditis, and a peculiar irregularity of the heart's action, without either, and without apparent cause, other than nervous phenomena, are occasionally met with. I have met with two cases of pericarditis which I could trace as the direct result of grippe; one a case of unusual severity, complicated with endocarditis, which resulted fatally in a few days. In one prominent case of irregular heart in my care, coming on the second day of a typical attack of grippe, uncomplicated with inflammatory or other lesions, I could find no cause other than a disordered stomach and nerves. The irregularity was so varied and prominent that I became apprehensive of the patient's life. At times the heart would beat normally for a few seconds, followed by a skip of one or two beats, then five or ten in rapid succession. This lasted for several days in a modified form after convalescence set in, and disappeared altogether when the patient regained her usual good health. The fever in

this case never rose above 99° F., but the headache, backache, aching in all the limbs and chilly sensations, were well marked.

The pneumonia complicating this disease is sometimes peculiar, when compared to uncomplicated pneumonia. It is often brought on by the patient's continuing his daily vocation, exposing himself to sudden changes of heat and cold, and trying to fight out the disease without taking any medicine. In this case he may have a number of slight chills, with fever varying from 99° to 101°, and finally takes to his bed from sheer exhaustion. On examination you may get the physical signs of both the first and second stages of pneumonia. I have heard the distinctive crepitant rale of the first stage at the top, while at the bottom of the same lobe there were bronchial breathing and dullness of the second stage. The second stage is frequently slow in developing, taking, sometimes, from two to five days to become solid. In like manner convalescence is slow, the lung remaining semi-solid for a varying period of time, ranging from two to five weeks. In some subjects these cases resemble both catarrhal and croupous pneumonia, but are distinctive types of neither. In bronchitis, as sequelæ, there is nothing of importance to note, more than in ordinary bronchitis, save, perhaps, its severity and prolonged duration, followed by extreme prostration. I have met with a few cases of gastric catarrh, which have been obstinate in the extreme. One case I recall in particular, in a middle-aged lady who went to bed in her usual good health, only to be awakened at midnight with a chill and severe headache, and backache, and aching in all her limbs, with extreme prostration. When seen, a day or two later, the tongue was laden with a thick, dark-brown coat, dry and parched, resembling a typhoid fever tongue. There was some vomiting and retching for the first three or four days, after which the stomach became settled, but all nourishment was taken with great reluctance throughout the continuation of the disease. The bowels were very costive, never moving without aid. There was no tenderness over the abdomen, nor tympanitis, save directly in the region of the stomach, which, when pressed upon, gave her a sickening and nauseating feeling. Her temperature ranged from 97½° of mornings, to 99° or 100° of evenings. It was six weeks before convalescence set in, and as many more before she was able to resume her household duties. Where gastric disturbance in children is a complication, vomiting is usually obstinate and severe; but where there is enteritis and diarrhœa, the stomach is usually less affected, and vomiting absent.

Intercostal neuralgia, lumbago and sciatica are not infrequent complications, and the suffering of the patient is sometimes so great that all remedies fail to give relief till a hypodermic of morphine is given. I recall one case of sciatica, superinduced by grippe, with all its characteristic phenomena, in which the suffering of the patient was so great that neither recumbency in bed or other position relieved the pain in the least, yet it subsided in a few days under treatment for the other symptoms. There is often a prostration following grippe, which leaves a person weak and unfitted for active business or labor for days, and sometimes even weeks, after all other symptoms have subsided. A peculiar feature about this is that the prostration is often out of all proportion to the attack of the disease. I have had patients in whom the onset of the disease was very mild, and

yet they would remain weak and of no account for days, bordering on nervous prostration. There is another important fact to which I wish to call especial attention, and that is the tendency of grippe to develop old chronic troubles, though dormant at the time, into acute outbreaks. Especially is this so with rheumatism, neuralgia, Bright's disease and iritis, a frequent sequela of rheumatism.

One other word, and then I shall have finished—and that is its tendency to relapse, in some cases, unless treatment is persisted in for a week or ten days after the prominent symptoms have subsided. During our recent epidemic I had quite a number of patients to return for further treatment several days after they had resumed their occupations and had felt quite well. These relapses are not usually like the acute onset, in that they are accompanied with a dull, heavy headache, a languid, tired and dull feeling, and a want of energy. Again, I have noticed that these relapses do not yield so readily to treatment as the original attack, but are apt to be accompanied by a low grade of fever, lasting for several days, and sometimes as many weeks. I have nowhere in this paper spoken of treatment, as it was not my intention to do so in the start, but I do want to say one word in regard to the above described relapses, and that is the efficiency of quinine to hold them in abeyance. Nowhere have I seen it better verified than in my own person. So long as I took six or eight grains of quinine during the twenty-four hours, I was able to attend to my practice. But if I left it off for twenty-four or forty-eight hours, the dull, heavy headache, languid and prostrate feeling returned.

INDICATIONS AND LIMITATIONS OF LAPAROTOMY IN PERITONITIS.*

By PINCKNEY FRENCH, M. D., of Saint Louis,
Professor of Surgery in the Barnes Medical College.

GEOGRAPHICALLY, the peritoneum has been divided into two areas—one, the area of the large intestine; and the other, the area of the small intestine.

The peritoneum over the large intestines is meagerly supplied with nerves and blood vessels, glands and lymphatic structures, and is fixed in its position and possesses limited absorbent power. The peritoneum over the area of small intestines is richly supplied with blood vessels, lymphatic structures, glands and nerves and is unstable as to position, and, as has been aptly said, covers the business portion of the digestive tract—an active secretory apparatus with almost unlimited absorbent power.

The peritoneum of the large intestine possesses functions of self-protection and protection of viscera which it surrounds; this enables it to guard the portals of life with great care.

From a scientific and practical standpoint, it is exceedingly important to recognize the fact that the conditions heretofore regarded as peritonitis

* Read before the St. Louis Medical Society, March 13, 1897.

in this region were curative, not destructive—that they were preventive of greater injury, not productive of it.

The term "plastic peritonitis" describes a condition that attends the healing of all aseptic wounds of the peritoneum, and is limited to the seat of the irritant and indicates a purely regenerative process, by which damage is repaired and further damage is prevented—a process that saves life, not inflammatory. Ability of this part of the peritoneum to localize, correct, remove, overcome or circumscribe the influence or injurious effects of all irritants is now readily recognized by experienced surgeons. If we exclude from peritonitis every process by which injuries or defects of the peritoneum are repaired, or by which danger to the abdominal viscera and general system are prevented, we will have set apart from consideration in this article almost every condition termed peritonitis. The conditions heretofore recognized as local plastic peritonitis, confined almost exclusively to the pelvic and appendicular regions and the region of the liver, is a life-saving process, the regeneration process of repair, marked by copious exudates even in the simplest wound or irritation, establishing barriers of self-defense, limiting the effects of septic invasion—burying sutures, ligatures and foreign bodies and absolutely controlling the influence of all irritants, save that produced by a permanent cause. The term suppurative peritonitis designates no inflammatory process, and refers simply to subsequent infection by pyogenic bacteria of the plastic exudates and regenerative material referred to above as incident to all forms of aseptic wounds, irritation, etc. The infection remains local, creating an abscess for the substantial reason that the antecedent condition of the peritoneum at the point of attack diminishes its absorptive powers, and thus prevents general infection.

For the relief of this condition, the achievements of surgery have been pronounced. Here is where we record our triumphs in peritoneal surgery, and as is usual, surgical success is along the line where Nature's efforts are victorious. This is the only variety of acute peritonitis amenable to laparotomy, and the operation is limited for benefits to the evacuation of the suppurative infections here described, which is always a purely local affection and situated along the line of the large intestines in regions mentioned.

Septic peritonitis is a term used to designate a condition which rapidly destroys life without any perceptible pathological change of the peritoneum—death resulting from the speedy absorption of septic material from the peritoneal cavity into the general system, producing a toxemia, a blood poisoning. This form of peritonitis affects almost exclusively the peritoneum of the small intestines, whose absorptive powers are so great as to rapidly disseminate the infection throughout the system. This area of the peritoneum is incapable of resisting infection or irritation by the use of exudates, and is the area of sepsis which produces death, not by peritonitis, but by blood poisoning. Here we record our failures in peritoneal surgery. No conditions exist that indicate laparotomy. We are not dealing with a circumscribed infection, relieved by the establishment of a surgical outlet for the evacuation of infectious material, as in the case of the peritoneum of the large intestines, but with a general systemic infection, not amenable to operative surgical relief.

The term "fibrino-plastic peritonitis" is unworthy of consideration, for the reason it is an attempt to straddle the diagnostic fence. Thus we conclude that laparotomy is indicated in acute peritonitis, only when the conditions present show a circumscribed purely local infection situated along the line of the large intestines. Then for the purpose of establishing an outlet for infectious material, and thereby preventing a general infection, laparotomy is limited to this form of acute peritonitis.

We remark that clinical observation has demonstrated that nearly all chronic inflammations of the peritoneum are tuberculous in their nature. When tuberculous peritonitis is associated with chronic pulmonary phthisis, tuberculous inflammation of the genito-urinary tract, or as one of the lesions of acute general tuberculosis, it is not a surgical lesion and is not likely to establish conditions that would be benefited by laparotomy, and the operation is not indicated in the tubercular peritonitis with general effusion occupying the whole peritoneal cavity.

Laparotomy is not indicated in what is known as the fibro-plastic or adhesive varieties of tubercular peritonitis, except for the evacuation of a fecal abscess or the relief of an intestinal obstruction. This is the least dangerous of the varieties that affect the region of the small intestines. It is usually very chronic and the layers of fibrin diminish the chance of general systemic infection. The old practice of opening the belly, attacking a mass of agglutinated intestines, breaking up extensive adhesions, dusting the raw serous surfaces heavily with iodoform and then closing or draining the peritoneal cavity, has not been productive of good results, and is no longer advised.

Laparotomy is indicated in all cases where there is a well-defined local tubercular focus, and reported successful cases have almost invariably been for the relief of collections in the iliac regions or along the peritoneum of the large intestines. Tuberculosis of these regions is more frequently of the circumscribed form. Laparotomy is also limited in its application to the circumscribed form of tubercular acites, which usually takes its origin from the floor of the pelvis. All purely local forms of tubercular peritonitis are surgical lesions, whether suppurative or not. Laparotomy is indicated in tubercular salpingitis and in tuberculosis of the uterus, and occasionally, though rarely, the operation should be done in tuberculosis of the bladder in connection with the operation suggested by Prof. R. Harvey Reed, of Columbus, Ohio, of disposing with the bladder by its removal and the implantation of the ureters into the rectum.

Consideration of the brief synopsis of the indisputable facts here presented, admits of but one conclusion—that laparotomy for the relief of the condition described under the term peritonitis is restricted to the purely local form of infections, and then done only for the evacuation of infectious materials.

Northeast Missouri Medical Association held its annual meeting April 6th, at Memphis. Dr. W. F. Mitchell, of Lancaster, was elected President; Dr. E. O. Sisson, of Keokuk, Iowa, Vice-President; Dr. O. F. Pile, of Memphis, Treasurer; and Dr. Frank B. Hillier, of Kahoka, Secretary. The next meeting will be held at Lancaster, July 6, 1897.

THE SQUAMOUS SYPHILIDE.

By A. H. OHMANN-DUMESNIL, of Saint Louis.

READERS of works on syphilology will find that, as a rule, the majority of the works devoted to this subject do not speak of the squamous syphilide as a distinct form of eruption, except in so far as it affects the palms and soles. Despite this, any one who has had the opportunity of observing a certain considerable number of cases of syphilis, cannot have failed to note the fact that occasionally one is met with in which a general eruption occurs, which becomes distinctly squamous in character. The clinical appearance is so marked, and its characteristics are so patent, that it is certainly entitled to a distinctive appellation. It is for this reason, principally, that I have given it the name which forms the caption of this article; and I am certain that the more these cases are studied, the more appropriate will the appellation appear. It seems strange that a name applied by the older authors was not only discarded but its proper substitute not adopted. The name applied formerly was that of syphilitic psoriasis, the name psoriasis indicating quite plainly the scaly nature of the eruption. It does closely resemble psoriasis to the untrained eye, and might possibly be taken as an example of that disease in certain cases, unless care were taken to accurately establish a differential diagnosis.

The term given above has been applied to this peculiar form of syphilitic eruption by the writer, simply because the prevailing character of the lesions is a squamous condition. If the exact history of such a case can be obtained, or if it has been continuously observed, it will be found that the trouble began as a papular or a pustular eruption, more often the former. Occasionally, it follows in the wake of a papulo-pustular syphilide. The papules or pustules do not seem to undergo their complete course of evolution, but rather suddenly subside to give way to another process, consisting of a greater or less proliferation of horny cells, which go to form the scales which are subsequently observed. These scales, when once formed, will often persist for quite some time, becoming stubborn to the best directed treatment and intractable to the ordinary therapeutic measures. The eruption is to be regarded as the result of either neglect of the original trouble or of insufficient or inadequate treatment. As a matter of fact, it is generally the former cause which is at fault, although cases may be observed, more especially of the palmar and plantar form, which will occur despite the best and most energetic specific treatment. But negligence on the part of the patient and carelessness to his condition will often result in a very rapid spread of the condition, which may manifest itself over very large areas of the integument, as shown in Figures 1 and 2. Ignorance of the disease or of its very existence may lead to an utter disregard of the trouble, and result in a case such as that shown in Figure 1, who was a young married woman infected with syphilis. Being a country girl, she had no idea of what the trouble was, and imagined that it was one of the regular accompaniments of the marital state. Neglect in such cases is certainly pardonable. In the case shown in Figure 2, the patient was a man whom a doctor treated for psoriasis, but with little success. Ignorance of the

nature of the real condition will not only bring about the condition depicted, but may occasionally lead to most serious and disastrous results which it will be found a most difficult task to even ameliorate. It is partly for this reason that the medical profession at large should make efforts to become more thoroughly acquainted with the commoner skin diseases and syphilitic manifestations.



FIG. 1. Squamous Syphilide in a Woman. (Back, Buttocks and Arms.)

Like all squamous affections of the skin, this particular syphilitic manifestation has a tendency to persist for a long time unless energetic measures be adopted, and even then the best directed efforts at times obtain but a very slight improvement. The condition of chronicity is apt to supervene in spite of all that is done. What concerns us more directly at

present is the question of diagnosis. This is not so difficult to attain, if but proper attention be given to the fundamental principles governing the matter. The distribution of the squamous syphilide, when it occurs upon the body, seems to be pretty general. The scales are white in color, thin,



FIG. 2. Squamous Syphilide in a Man. (Back and Arm.)

and individually they are not very large. This is well shown in Figures 2 and 3. If these scales be removed they proliferate so quickly that there is a rapid return. In fact, rapid proliferation of the horny cells seems to be one of the main characteristics of this eruption. The scales are but slightly adherent, and their removal causes no bleeding. The base of a

patch, however, is markedly erythematous, and presents a more or less angry appearance, and, in some cases, may exhibit a very slight moisture. This exudation, however, is not sufficient in quantity to lead to the formation of crusts, and is really nothing but a very slight amount of serum, which is derived from the engorged blood vessels. On the other hand, in the majority of cases, the integument is perfectly dry, no moisture about the lesions being observed in the palms, which are usually well supplied with coil glands. The dryness in this locality is well shown in Figure 3. The eruption on the body differs in many respects from that observed on the palms and soles. In the latter, the patches are sharply limited in contour, and there seems to exist a tendency to the rapid establishment of a hyperkeratosis. The squamæ have their contours well defined and sharply separated from the normal skin. In addition, the proliferation of horny tissue has a tendency to assume the characters of corns or clavi, which patients will pick out with the point of a pen-knife, leaving small conical depressions. This peculiar condition in which clavi occur is certainly interesting, and is one deserving of separate consideration. Suffice it to say



FIG. 3. Squamous Syphilide of the Palm.

that it is looked upon as a pathognomonic sign of syphilis, as no cases have been recorded of such a condition existing in other cutaneous troubles.

In the squamous syphilide the proliferation of scales is comparatively abundant. The friction of the clothing on the trunk and limbs causes a continual shedding of the most superficial horny accumulations, and the consequent renewal is quite rapid. In consequence of this, a patient affected with this form of eruption is constantly losing a considerable quantity of these horny exfoliations, which, if gathered together, would make quite a considerable quantity each day. This constant loss, whilst annoying, does not cause any debility or occasion other untoward symptoms of any marked character. But it has quite a considerable influence in retarding recovery, so far as local symptoms are concerned. Internal medication seems to be impotent in securing a disappearance of these scaly lesions. It can be observed that in those localities in which the friction of the clothing is only moderate, the squamous syphilide is much less marked and does not change in form. In those localities, on the other hand, in which marked pressure and friction occur, it is not unusual for excoriations

to manifest themselves. Some of these erosions may be seen on the left of the subject shown in Figure 2, in which the region of the elbow is implicated, and shows the effects of pressure consequent upon leaning on the part. A fact worthy of note in connection with this eruption is that it occurs for the most part on the extensor surfaces, the flexors not being its seat, or to a limited degree only. The palms and soles are very frequently implicated, and the face very rarely or never. From the hasty sketch which has just been outlined a diagnosis should not be difficult to make.

The only affections of the skin for which the squamous syphilide might be mistaken are psoriasis, ichthyosis, exfoliative erythema, or pityriasis rubra. In psoriasis, the scales are silvery-looking and quite adherent. A scaly patch is elevated at its edges, and quite sharply defined against the normal skin. This elevated edge is quite a bright red in color, and the lesions assume particular shapes, being roundish or ovalish in contour, or gyrate. The sites of predilection are the elbows, knees and buttocks. The scalp is not infrequently affected, and, so far as I have been able to observe, the extensor and the flexor surfaces are affected simultaneously. In other words, there is no particular preference for either. The palms and soles are so rarely affected by psoriasis, that it has given rise to a grave doubt whether it is really psoriasis, and not a squamous syphilide, which is observed in such cases. This is certainly a question which merits further study. A sign which cannot fail to establish a diagnosis, and which is looked upon as pathognomonic, is that so commonly employed in connection with psoriasis. In this disease, if the scales, which are quite adherent, as mentioned above, be forcibly separated from the underlying structures, a number of minute bleeding points will declare themselves. If this peculiar bleeding does not occur spontaneously, all that is necessary is to pinch the skin gently, and it will occur in psoriasis. In syphilis, there will be no evidence whatever of any bleeding.

So far as the differential diagnosis between the squamous syphilide and ichthyosis is concerned, the matter is a very simple one. In ichthyosis we merely have a hypertrophy of the horny cells of the epidermis, and the history of the trouble is that it was always the same, and has existed from childhood. It does not manifest itself in small patches, but rather in extensive areas, more especially the outer aspects of the thighs. When occurring about joints, it is chiefly on their extensor aspects, and here there is a very marked thickening of the skin. The general appearance of the ichthyotic condition, as its name implies, is a resemblance to the scales of a fish. The scales themselves are whitish, greyish, or dirty looking. They can be separated, but with difficulty; and, when this is done, the underlying integument presents a healthy appearance.

In exfoliative erythema we have a condition presented which is very interesting. It has been erroneously supposed by some to be of syphilitic origin, whereas it is most probably a symptom of a reflex neurosis. It is sudden in its onset, and very apt to recur, and usually at regular periods. It is characterized by a marked erythema of the integument and a desquamation of the skin in large flakes. The entire skin shares in this peculiar shedding, large sheets coming off the trunk, and gloves and moccasins off the hands and feet. There would be little likelihood to mistake this for a squamous syphilide, but a recognition of its true nature will

prevent the observer from falling into the error of giving anti-syphilitic treatment for it.

Pityriasis rubra is another squamous disease, which is seen so seldom that it may also lead to erroneous ideas. It is an inflammatory trouble of the skin, generally associated with some other disturbing element, such as heart disease. In this affection the entire skin becomes very red, the patient is generally depressed, and the vitality is below par. The desquamation is continual, the scales being large and papery. It is so considerable in quantity, that a patient will shed a bucketful of the scales every day, and they seem to regenerate as fast as they are cast off. Of course, no mistake could be made between this condition and the squamous syphilide, by any one possessing but a rudimentary knowledge of skin diseases, and yet we have seen such cases pronounced syphilitic.

The treatment of this form of syphilis is one which requires more than ordinary care and attention. This can be the more readily appreciated when it is taken into consideration that the external treatment is not only of prime importance, but that the application of mercurials externally will so accentuate the effects of the drugs, more especially when applied to so extensive a surface as shown in Figures 1 and 2, and at frequent intervals, that severe mercurial intoxication would follow in a very short time. If the internal administration of mercury should be added to this, it is easy to conceive how easily a severe if not fatal mercurial intoxication would be brought about. Such results are certainly neither desired nor desirable, and for this reason some care is absolutely necessary in the local treatment, in order that the remedies which may be employed may not too strongly accentuate the effects of the internal remedies which are adopted. It is for this reason that much discrimination should be used, as an injudicious course might not only prove disastrous, but produce symptoms much worse than the original condition. It is very often a question as to whether internal treatment should not be first given so as to obtain better and more rapid results, so far as the cutaneous lesions are concerned. There can be no doubt, whatever, that both internal and local measures must be employed.

In administering an internal remedy, two facts are to be taken into consideration—the length of time the disease has existed, and the sex of the patient. In the case shown in Figure 1, the subject was a woman in whom the disease had not existed for more than a few months, and had been untreated, because unrecognized. In such a case the treatment could not be the same as that in the case shown in Figure 2, in which syphilis had manifested itself a year previous, and in which a certain amount of treatment had been given. It will be readily understood that, under such varying conditions, the same measures could not be adopted. In the former case, being a female, and the disease being seen at its outset, a fourth grain of protiodide thrice daily was administered with marked benefit. The treatment to be pursued after this must, of course, be governed by the indications which present themselves. In a man who should become the subject of the squamous syphilide, at the beginning of the disease it would be better to give him a mixture composed somewhat as follows:

℞ Hydrargyri bichloridi, gr. iij.
 Kali iodidi, ʒ iv.
 Kola kolafra, ʒ ijss.
 Aquæ destillat, ʒ ijss.

M. Sig.: Two teaspoonfuls after each meal.

After a course of two weeks of this treatment has been given, it may be profitably followed up with a biniodid of mercury pill containing an eighth grain of the salt thrice daily after meals. This is merely a general indication of the general treatment to pursue, as it is apt to need modification in any special case which may present itself. One point which should not be forgotten is that it is absolutely essential that mercurials are to be given and the avoidance of the administration of iodide of potassium in excessive quantity avoided. The latter is very apt to produce more harm than good, if too little attention has been paid to the former.

So far as local applications are concerned, it is an important point to remember that in the various squamous eruptions of syphilis mercurial treatment is not particularly indicated. As a matter of fact, mercurial applications will have little or no effect, whereas keratolytic agents will have a tendency to rapidly soften and destroy the accumulations of horny tissue which manifest themselves in the form of rather thick scales, as shown in Figures 1 and 2. In order to bring about this softening and clearing up of the skin, which is absolutely essential to permit the proper remedies an opportunity to act, a warm or even hot bath is first ordered. Then the patient is to apply thoroughly to every portion which is scaly, the following mixture:

℞ Saponis viridis,
 Alcoholis, aa ʒ iij.
 M.

It is pretty thoroughly rubbed in and permitted to remain on for a period of time varying from ten to twenty minutes, the length depending largely on the amount and thickness of the squamous accumulations which are to be removed. At the expiration of this time a full bath is taken, and it will be found that all or nearly all of the scales have been removed. After thoroughly drying the skin, one of the following mixtures should be very sparingly applied to the affected portions and no unnecessary friction indulged in, as the object is to have as little absorption as possibly by way of the integument:

℞ Hydrargyri bichloridi, gr. iv.
 Ammonii muriat., gr. x.
 Aquæ rosæ, ʒ viij.
 M.

A more oleaginous preparation is the following, which is preferred by some patients:

℞ Hydrarg. oleat. 5%, ʒ ij.
 Ol. amy dal. dulc., ʒ ijss.
 Ol. lavandulæ, ʒ ij.

M. Sig.: Apply thin once a day.

Another plan of treating locally this condition when the eruption covers a considerable area is to dispense with the preliminary bath and rub in thin once a day the following ointment:

℞ Acidi salicylic, ʒ ij.
 Ung. aquæ rosæ, ʒ iv.
 M.

The ointment should be sparingly used, but well rubbed in. The scales will disappear in a comparatively short space of time and then a good, full bath will clean the skin thoroughly and prepare it for the mercurial treatment, which shall be next in order. This should consist of mercurial fumigations given every other day. This is a most excellent method, as it possesses quite a full local action with little, if any, absorption of mercury by this method.

In the case of the plantar and palmar squamous syphilide, an example of the latter of which is shown in Figure 3, a different mode of local treatment must be adopted, in view of the fact that the horny process is so much more pronounced, due to the fact that the epidermis is so much thicker in these localities. The method which I have found most efficient is the thorough application of an ointment similar to that used in psoriasis. It may be made after the following formula:

R Chrysarobini, gr. xv.
 Acid. salicylici, ʒ j.
 Ichthyol, ʒ i.
 Ung. aquæ rosæ, ʒ i.
 M.

This should be rubbed in thoroughly once a day, and it will not be long before the keratosis will have disappeared. Pinkish, tender places will remain to indicate the former sites of the horny and squamous lesions. When this condition is present, the ordinary mercurial ointment should be ordered rubbed in quite thin once a day, and if it should prove at all irritating, it should be mitigated by the addition of lard or of lanoline. Irritation of any sort should be avoided, as it may delay a rapid return to the normal, which is the object of the treatment.

Such is a brief outline of one of the troublesome forms of syphilitic eruption, as well as one of the most stubborn to constitutional measures unaccompanied by local methods of treatment. It is, in many instances, terrifying to the patient, and no less disliked by the physician, who is often at a loss to account for his lack of success in treatment, when this latter is wholly dependent upon his negligence in adopting proper local remedial measures. On the other hand, the proper course is not only conducive to the peace of mind of the unfortunate victim, but it also becomes a source of satisfaction to his medical attendant when rapid and most excellent results follow, as they naturally will. A rational treatment, based upon sound principles, must always result in good effects, and in no disease can such be as readily obtained as in syphilis.

The Linton District Medical Society will hold its spring meeting at Mexico, Mo., May 4 and 5, 1897. The officers are: Dr. T. J. Baskett, of Mexico, President; Dr. S. S. Davis, of Fulton, First Vice-President; Dr. J. A. Evans, Second Vice-President; Dr. Peter Arnold, of Wellsville, Secretary; and Dr. Martin Yates, of Fulton, Treasurer. Papers will be read by Drs. Woodson Moss, of Columbia; J. C. Parish, Vandalia; J. F. Graves, Montgomery City; C. A. Halley, Mexico; R. S. Austin, Molino; M. E. Crawford, Mexico; W. F. Taylor, Martinsburg; Dr. Connaway, Columbia; H. H. Middlekamp, Warrenton; and Dr. Pearson, of Louisiana.

SOME FIGURES SHOWING THE CURABILITY OF CANCER OF THE UTERUS.

By EMORY LANPHEAR, M. D., Ph. D., LL. D., of St. Louis, Formerly Professor of Operative Surgery in the Kansas City Medical College, and Professor of the Principles and Practice of Surgery in the St. Louis College of Physicians and Surgeons.

IN an address before the Medical Society of the State of New York, delivered January 26, 1897, Joseph Eastman, M. D., L.L. D., of Indianapolis, Indiana, gave a most remarkable report of one hundred and fourteen vaginal hysterectomies for cancer of the uterus, *with fifty per cent. of cures*. This should forever settle the question, "Is cancer of the uterus a curable disease?" in the affirmative, and lead to more frequent operation upon this common disease.

I have recently gone over my own case records (in the preparation of a paper to be read before the Texas State Medical Society), and find a condition also very favorable to the radical operation for uterine carcinoma. The figures are as follows:

Total number of hysterectomies.....	97
Cases that have lived more than five years.....	8
Cases that have lived more than three years.....	22
Cases that died from operation, or very soon after.....	14
Cases of known recurrence.....	4
Cases of suspected recurrence (not verified).....	8
Cases still within danger period (and some possibly recurring).....	41

These records show a primary mortality of thirteen per cent., which is entirely too high. The high-death rate is due to the fact that in my early enthusiasm I operated upon cases too far advanced for any hope of survival—cases I would not now subject to operation. My last thirty-one cases give a primary mortality of only six per cent., which is about the average of danger under our present careful methods of operating.

It will be noticed in the last line of the table that the present condition of forty-one is unknown. The explanation is that a few of the older cases cannot yet be traced; and that no special attempt is made to determine recurrence until at least two years have passed, though if recurrence takes place within that period, it is almost invariably reported by the family doctor.

The Missouri State Medical Association will meet in St. Louis, May 18, 19 and 20. All the first, second and third day until noon will be devoted to the scientific program. On the evening of the first day the Association will, as a body, attend a session of the Illinois Society, in East St. Louis. On the evening of the second day the Illinois Society will attend, as a body, a session of the Missouri Association, after which there will be a banquet and reception. On the third day both bodies will adjourn and join in a steamboat excursion on the river.

FORMULÆ.

Malarial Poisoning.—The following seldom fails in cases of so-called malarial poisoning:

- ℞ Quininæ sulph., ʒ iss.
Ext. eucalyptus, fl ʒ ij.
Gingerine, gr. viij.
Acid hydriodic, q. s. ʒ vj.

M. Sig. Teaspoonful in water after each meal.—*North Amer. Med. and Rev.*

Palatable Mixture for Chills.—The following may possibly serve your purpose:

- ℞ Quinine sulphate,
Cinchonine sulphate, ʒ ij.
Sulphuric acid, to dissolve.
Ol. orange, to flavor.
Saccharin, gr. viij.
Alcohol,
Glycerin, aa fl ʒ ij.
Syr., to make fl ʒ xvj.

Dissolve the quinine and cinchonine in 4 fluid ounces of the syrup by means of the sulphuric acid. Dissolve the oil orange, or other suitable flavoring, and saccharin in the alcohol and glycerin, add it to the quinine solution, and, finally, add sufficient syrup to make the mixture measure one pint.

- ℞ Quin. sulph., gr. xv.
Dil. sulph. acid, m xv.
Spir. peppermint, fl ʒ iij.
Satur. solut. saccharin, m v.
Aq. dest., fl ʒ vj.

M. Acetanilid may be kept in solution with syrup, or water, by first dissolving it in sufficient alcohol, in which it is fairly soluble.—*Merck's Market Report.*

Small-Pox.

- ℞ Atropinæ sulphat., gr. j.
Aq., fl ʒ ss.

M. Sig. Three to five minims every three or four hours.—*Hitchman.*

- ℞ Acid. salicylic, gr. xx.
Sodii bicarbonat,
Ammon. carbonat, aa gr. iv.

M. Et ft. chart. No. i. Sig. Take in water every two to four hours.—*Prideaux, Dominion Med. Monthly.*

Heart Diseases.—In fatty heart, dilation of cavities and mitral regurgitation with anæmia.

- ℞ Ferri redacit.,
Pulv. digitalis fol. (English),
Quininæ sulphatis., aa ʒ j.
Pulv. scillæ, gr. x.

M. Ft. massa et in pil. No. xx div. Sig. A pill three or four times daily.—*Bartholow, Ex.*

Solution for Painless Extraction of Teeth.

- ℞ Hydroch. cocaine, gr. iij.
Hydroch. morphine, gr. ¼.
Chloride sodium, gr. iv.
Antipyrin, gr. xxx.
Guaiacol, gtt. ij.

Distilled and sterilized water, a sufficient quantity to make 3½ ounces.

M. Sig. Inject a few drops around the tooth.—*Ex.*

Tetanus.

- ℞ Chloral hydrat., ʒ ss.
Syr. aurant. cort., fl ʒ iss.
Aq., ad fl ʒ iij.

M. Sig. Dessertspoonful as required.—*Bartholow.*

- ℞ Pulv. opii, ʒ j.
Pulv. camph., gr. xv.
Adipis prep., ʒ ss.

M. Sig. Rub the parts affected with the spasm.—*Thomas.*

- ℞ Cocain. muriat.,
Morphiæ muriat., aa gr. xij.
Aq. dest., fl ʒ j.

M. Sig. Twenty to sixty minims hypodermically, as required.—*Lopez, Dominion Med. Mon.*

Soothing Application for Acute Eczema.

- ℞ Bismuth oxid., ʒ j.
Acid. oleic., ʒ j.
Cera alb., ʒ iij.
Vasellini, ʒ ix.
Ol. rosæ, m ij.

M. Sig. For external use.—*Hyde, Ex.*

For Ulcers of the Mouth.

- ℞ Campho-Phenique ʒ i.
Sig. Apply on cotton swab to each ulcer.—*Ex.*

TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

Issued Monthly for One Dollar a Year.

EDITORIAL DEPARTMENT.

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JAMES MOORES BALL, M. D.,	-	-	-	-	} Editors.
R. C. BLACKMER, C. M.,	-	-	-	-	
OTHO F. BALL, M. D.,	-	-	-	-	

Business Manager.

Address all communications, news of medical interest, subscriptions, etc., to the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER, 3509 FRANKLIN AVENUE, ST. LOUIS.

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A CONTRAST.

The MISSOURI Legislature has just adjourned, after passing a bill to legalize the practice of "Osteopathy," whatever that may be. Our Governor, who, by the way, is noted as an advocate of the rankest nepotism, signed the bill, thus making it a law.

IOWA has a new medical law creating a Board of Medical Examiners—a law which says:

SEC. 6. Every physician practicing medicine, surgery, or obstetrics, or professing or attempting to treat, cure or heal diseases, ailments, or injuries, by any medicine, appliance, or method, who goes from place to place, or from house to house; or by circulars, letters or advertisements, solicits persons to meet him for professional treatment at places other than his office at the place of his residence, shall be considered an itinerant physician; and any such itinerant physician shall, in addition to the certificate elsewhere provided for in this chapter, procure from the State Board of Medical Examiners a license as an itinerant, for which he shall pay to the Treasurer of State for use of the State of Iowa the sum of two hundred and fifty dollars per annum. Upon payment of this sum the secretary shall issue to the applicant therefor a license to practice within the State, as an itinerant physician, for one year from the date thereof. The board may for satisfactory reasons refuse to issue such license, or may cancel such license upon satisfactory evidence of incompetency or gross immorality. Any person practicing medicine as an itinerant physician as herein defined without having procured such license shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than three hundred dollars, nor more than five hundred dollars and costs and shall be committed to the county jail until such fine is paid; *provided*, however, that nothing herein shall be construed to prevent any physician otherwise legally qualified from attending patients in any part of the State to whom he may be called in the regular course of business, or in consultation with other physicians.

SEC. 7. From and after January 1, 1899, all persons beginning the practice of medicine in the State of Iowa must submit to an examination as set forth in this chapter, and

in addition thereto, shall present diplomas from medical colleges recognized as in good standing by the State Board of Medical Examiners, and all persons receiving their diplomas subsequent to January, 1, 1899, shall present evidence of having attended four full courses of study of not less than twenty-six weeks each, no two of which shall have been given in any one year.

A SNIDE MEDICAL COLLEGE.

In the March issue of the *Iowa Medical Journal* we note an editorial on "Snide Medical Colleges," which is well worth reading. The college referred to particularly is the Medical Department of Drake University, known by the high-sounding name of the "Iowa College of Physicians and Surgeons." Dr. Kime says:

"That there is one too many medical colleges in the State of Iowa has just been evidenced by the graduation of a class from a medical college at Des Moines. Until the hour had almost arrived for examinations to begin, it was believed by us that the school was one that, although it needed some changes to bring it up to grade, would graduate its class upon merit alone. When it came our turn to examine the graduating class, we were told to 'Go over and write the questions on the black-board and go home and turn the class over to the janitor.' *Shades of Hippocrates! Turn the class over to the janitor for examination!* We found upon investigation that this was being done by most of the members of the faculty. We, however, refused the suggestion and remained with the class from 9 A. M. until noon, when all had completed their papers. We found also upon inquiry that the most flagrant cheating had been indulged by members of the class by this system. Books had been used, papers had been passed through holes in the wall to those in the examination room and notes freely handed from one to another, and that those being examined went out and in from the room at will.

'Many of the best students came to us and complained that the sluggards in the class would pass better examinations than they would because of the cheating indulged in. The results showed that their surmises were correct. At a faculty meeting afterward, Dr. E. H. Hazen took the floor and protested against the turning over of the class to the janitor for examination, because the better class of students, who would not cheat, objected to the method.

"A protest has been filed with the State Board of Medical Examiners against the recognition of the diplomas and demanding examination by the-board.

"Little pretense has been made to the maintenance of order or of common decency in the school.

"About one month before commencement one of the ladies—who was a lady in every sense of the word—and one of the gentlemen, who one month later carried off the class honors at graduation, incurred the displeasure of some of the ruffians in the class.

"In consequence of this, there appeared upon the black-board the following vulgar prescription:

R Miss Y (a lady of the class).
 Mr. X (a gentleman of the class).
 M. Sig.: One screw every three hours.

"(We had thought to withhold this prescription, owing to its extreme vulgarity, but we believe it our duty to show the condition exactly as it exists, and let each physician judge for himself of the justness of the protest filed.)"

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER has long considered the Des Moines school a disgrace to the profession and the good people of Iowa. We would have shown it up long ago, if we had possessed the evidence. While morally certain that crooked work was being done, we did not have evidence of such a character as would justify us in taking the responsibility. We congratulate Doctor Kime that he has the courage to expose such a school in his own city; we congratulate the good people of Iowa that such a vile nest is to be destroyed; we congratulate the medical profession of the Hawkeye State that it will soon have one medical college less; and we congratulate ourselves that we long ago incurred the displeasure of Lewis Schooler and his gang of "professors."

FIFTH ANNUAL MEETING OF THE TRI-STATE MEDICAL SOCIETY.

The recent meeting of the Tri-State Medical Society of Iowa, Illinois and Missouri was one of the best ever seen in this city. The Society was fortunate in having the presence of some of the leaders of American medicine and surgery. The clinics, thanks to the courtesy of Dr. Otto Sutter, Superintendent of the City Hospital, were of the greatest interest. The Medical Clinic was held by Dr. James T. Whittaker, of Cincinnati, the well known author and teacher. The Surgical Clinic, by Dr. Joseph Price, of Philadelphia, was highly appreciated. Dr. Dudley S. Reynolds, of Louisville, held the Ophthalmic Clinic. Dr. A. H. Ohmann-Dumesnil, of this city, held an interesting Skin Clinic, in the course of which he presented a case of Addison's disease. Dr. Alexander Hugh Ferguson, of Chicago, operated on a case of suppurating dermoid of the ovary. Dr. Fenton B. Türck, of the same city, made some demonstrations of the diagnosis and treatment of cases of gastric diseases.

At the "smoker," Dr. G. Frank Lydston, of Chicago, entertained the members with "An Original Doctor's Story, With Plenty of Points." His effort was a splendid one, and was highly applauded. Dr. Arthur E. Mink, of St. Louis, kept the audience in a roar from start to finish.

Important papers were read by the following gentlemen: "The Cause and Treatment of Epilepsy," by J. W. Fowler, of Dubuque, Iowa; "Gonorrhœal Synovitis," by E. J. Senn, of Chicago; "The Treatment of Pulmonary Tuberculosis by the Hypodermic Method," by Robt. O. Cross, of Kansas City; "Presentation of a Cretin—Remarks on Treatment With Thyroid Extract," by H. H. Vinke, of St. Charles, Mo.; "The Necessity of Special Institutions for the Treatment of Pulmonary Tuberculosis," by A. C. Klebs, of Citronelle, Ala.; "A Plea for the Early Recognition and Operative Treatment of Cancer of the Uterus," by O. Beverly Campbell, of St. Joseph; "Talipes Equino-Varus, Surgery of," by C. E. Ruth, of Keokuk; "Some Phases of Narcomania," by W. F. Waugh, of Chicago; "The Mouths of Our School-Children," by Carl Theodor Gramm, of Chicago; "The Relation of the Science of Medicine to Public School Education," by John Punton, of Kansas City; "Cholechololithotomy in America," by Alex. Hugh Ferguson, of Chicago; "Urinalysis, a Method of," by James A. Close, of St. Louis; "Lymphadenoma," by J. C. Spohn, of St. Louis. All the papers were of a high order.

The following new members were received:

H. H. Vinke, St. Charles, Mo.—St. Louis Medical College, 1882.

W. F. Waugh, Chicago—Jefferson Medical College, 1871.

Edwin Klebs, Chicago—Berlin University, 1857.

Edwin Borck, St. Louis—University Med. College, Baltimore, 1862.

A. Rhu, Marion, Ohio—Western Reserve University, 1885.

O. B. Campbell, St. Joseph, Mo.—Jefferson Medical College, 1884.

Robert O. Cross, Kansas City, Mo.—Kansas City Med. College, 1889.

G. R. Highsmith, Carrollton, Mo.—Missouri Medical College, 1875.

Wm. A. Tichenor, Chicago—St. Louis Medical College, 1879.

A. C. Klebs, Chicago—Basel University, 1892.

Carl Pesold, St. Louis—College of Physicians and Surgeons, 1890.

E. J. Senn, Chicago—Rush Medical College, 1893.

Frank Ring, St. Louis—College of Physicians and Surgeons, 1892.
 W. C. Carter, St. Peters, Mo.—College of Phys. and Surg., Balt., 1888.
 H. C. Dalton, St. Louis—Missouri Medical College, 1870.
 M. G. Roberts, Conway, Mo.—College of Physicians and Surg., 1891.
 W. J. Alexander, Marthasville, Mo.—Trinity Medical College, 1890.
 M. P. Overholzer, Harrisonville, Mo.—Kansas City Med. Col., 1884.
 W. H. Mayfield, St. Louis—College of Physicians and Surgeons, 1880.
 L. H. Laidley, St. Louis—Jefferson Medical College, 1868.
 S. VanHoefen, St. Louis—Missouri Medical College, 1873.
 J. C. Spohn, St. Louis—University of Michigan, 1868.
 J. C. Thurman, St. Louis—Barnes Medical College, 1894.
 J. W. Fowler, Dubuque, Iowa—University of Michigan, 1884.
 Carl Theodor Gramm, Chicago—Keokuk Col. of Phys. and Surg., 1893.
 George F. Hulbert, St. Louis—St. Louis Medical College, 1880.
 T. Gaffner, Trenton, Ill.—Missouri Medical College, 1889.
 F. E. Kuhlmann, St. Louis—St. Louis Medical College, 1896.
 John T. Walsh, Cairo, Ill.—College of Physicians and Surgeons, 1895.
 G. Frank Lydston, Chicago, Ill.—Bellevue Medical College, 1879.

NEW OFFICERS.

The new officers are these: President, Emory Lanphear, of St. Louis; Senior Vice-President, C. E. Ruth, of Keokuk, Iowa; Junior Vice-President, E. Wyllys Andrews, of Chicago; Treasurer, C. S. Chase, of Waterloo, Iowa; Secretary, J. W. Fowler, of Dubuque, Iowa.

The next meeting will be held in Dubuque, Iowa, the first Tuesday, Wednesday and Thursday of April, 1898.

THE EXHIBITORS.

The Zumo Pharmacal Company, of this city, was represented by Messrs. G. H. Willett and F. M. Reeves.

The A. S. Aloe Co. had a very fine line of surgical instruments, which were handled by Mr. F. J. Berger and W. H. McGee. This firm has recently issued a sixteen-page circular of specialties.

The White Rock Ozonate Lithia Water Co., of Waukesha, Wis., was represented by Mr. F. C. Parker, of Quincy, Ill., and Mr. Charles Caffall, of this city.

Fairchild Bros. & Foster were ably represented by three gentlemen—Messrs. O. W. Schmidt, W. C. Church and B. A. Gardner. This booth was a center of attraction.

The W. T. Keener Co., dealers in medical books, had Mr. Fred. Colegrove and Mr. Hoagland on the scene of action.

Charles Marchand, of peroxide fame, was represented by Mr. W. T. Berry.

The Holekamp-Moore Instrument Co.'s display was in the hands of Mr. E. Willbrandt and Dr. J. W. McMahan.

Mr. Ed. Remick and Mr. A. C. Newberger were in charge of the fine display of **Wm. R. Warner & Co.**

The Bles-Moore Instrument Co., dealers in fine surgical instruments, occupied one of the most prominent booths, where the jovial Dr. J. W. Moore was to be found.

The **Phenique Chemical Co.**, of this city, made a fine showing. Many physicians were interested in their goods. Mr. George Remick and Mr. John Crouch were in charge. This firm has recently placed a line of soaps and gauzes on the market.

The merits of the **McDannold chair** were shown by Dr. McDannold. He has recently invented a table for surgical use which seems to be about perfect.

The **Allison Chair Co.** was represented by Messrs. J. A. Dugan and F. N. Roberts.

The **Mellier Drug Company**, of St. Louis, had an interesting exhibit of Tongaline, and also showed some very fine medical portraits. Mr. Duncan Mellier is the happy possessor of a new story about Noah and the animals. Ask him about it.

The **Tilden Company**, of New Lebanon, N. Y., and St. Louis, made a good showing.

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter V.

THE DOCTOR AS A CHRONIC KICKER.

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- | | |
|-------------------------|--------------------------|
| 1. Dr. Newcomer. | 6. Titles. |
| 2. Tartar Emetic. | 7. A Would-be President. |
| 3. A Professional Card. | 8. Gratis versus Free. |
| 4. Sociable Neighbors. | 9. Dr. Sour. |
| 5. The Hitching-Post. | 10. Private Hospital. |

DR. NEWCOMER.

In 1870, a physician came to this city from the east; he had been in practice for a number of years, and had served as a surgeon for three years in the U. S. army. While prospecting around for a location, he naturally came in contact with some of the most prominent men of the profession.

The new arrival had two faults: first, he was of a quiet nature; second, he was extremely youthful in appearance; two inexcusable faults, to begin with, which did not escape the observation of some of the leading men.

Among the stars then in ascendancy was a German, Dr. H—, professor of surgery in one of the medical colleges, acknowledged to be a man of learning; he possessed an aggressive nature, and enjoyed nothing more than a quarrel in some form or other.

Meeting this distinguished man, Dr. Newcomer was approached by him thus:

Prof. H.: How do you do? Have you found a location? Do you intend remaining here?

Dr. Newcomer: I am in no hurry; but I shall locate here.

Prof. H.: I understand that you intend practicing surgery exclusively.

Dr. Newcomer: Well, what about that? For your benefit and for the information of other inquisitive individuals, I shall say I will settle here somewhere, begin with a general practice, and continue in it, possibly, for several years. I shall wait until patients come, attend them faithfully, and if a surgical case presents itself, the patient willing, I shall operate. At any rate, I shall not send my cases to you or any other surgeon; I shall try to keep them and do the work myself.

Prof. H.: Let me tell you, as a friend, that I think you are in the wrong place. The surgical practice is limited to a few; we have Drs H—, G—, P—, and McY—, and also of the other school, and I myself control my school and the German element. If I were you I should go to Chicago; that's the place! You are young, and will not be able to fight these old stand-bys, etc.

Dr. Newcomer: Thank you, Professor, for your valuable information. If what you say is true, it appears to me that this is the very place in which I shall remain; the city is growing, I am young and can wait. You are all much older men, and after you are dead there will be something left for me. When you came here, years ago, you were a stranger; you did not send your cases away, but you did some fighting. I shall not fight *anybody*. I did not come with that intention. I have come to practice my profession and take care of myself. However, I am exceedingly obliged to you for your good-will and fatherly advice. Hope to meet you again.

Dr. Newcomer had located and hung out his shingle. His card read as follows: "Dr. Newcomer, Late Surgeon U. S. Army, Office," etc.

He had not heard from his professional friend for some time. In the mean time Dr. Newcomer had also joined the medical society.

One day the door of his office was hurriedly opened, and in strode the Professor.

Prof. H.: Well, I see you have started. How is the practice?

Dr. Newcomer: My practice never troubles me. I paid the milkman this morning. I have a compound comminuted fracture on hand, the result of a street car accident; that is all.

Prof. H.: Is this your card?

Dr. Newcomer: Yes, sir.

Prof. H.: Well, Dr. Somebody says that he will bring charges against you in the medical society. This "Late Surgeon U. S. Army" is against the code, and is not to be tolerated. I do not *care*; I merely warn you. You should have omitted it.

Dr. Newcomer: Thanks for the interest you take. Dr. Somebody, no doubt, is one of your lieutenants; he sent you here with this message. Will you be kind enough to return one from me telling the gentleman he would oblige me very much by bringing the charge; and I wish he would call on me and give me a kiss.

Prof. H— never spoke again to Dr. Newcomer. The charges were never heard of, and Dr. Newcomer outlived Prof. H—.

[TO BE CONTINUED.]

PRELIMINARY ANNOUNCEMENT AND PROGRAM
OF THE
TWENTY-NINTH ANNUAL MEETING
OF THE
TEXAS STATE MEDICAL ASSOCIATION,

Tuesday, Wednesday, Thursday and Friday, April 27th, 28th,
29th and 30th, 1897.

THE CITY HALL, PARIS.

COMMITTEES AND OFFICERS.

Committee of Arrangements—R. R. Walker, Chairman; W. M. Moore, Joseph Meyer, L. P. McCustion, J. W. Haden, B. V. Ellis, J. B. Chapman, Thos. Moody, J. M. Hooks.

Reception Committee—Geo. S. Steel, Chairman; R. R. Walker, B. F. McCustion, G. W. Bedford, W. C. Farmer, G. W. Smith, A. J. Rush, W. H. Rush.

Entertainment Committee—L. P. McCustion, Chairman; J. W. Stephens, W. S. Baldwin.

OFFICERS.

President, J. C. Loggins, Ennis; *First Vice-President*, A. N. Denton, Austin; *Third Vice-President*, David Cerna, Galveston; *Secretary*, H. A. West, Galveston; *Treasurer*, J. Larendon, Houston; *Orator*, J. O. McReynolds, Dallas.

OFFICERS OF SECTIONS.

1. *General Medicine*—Lawrence Ashton, Dallas, Chairman; H. L. Tate, Lindale, Secretary. 2. *Obstetrics and Diseases of Children*—A. M. Douglass, Covington, Chairman; R. L. Miller, Denton, Secretary. 3. *Surgery*—Bacon Saunders, Fort Worth, Chairman; A. C. Scott, Temple, Secretary. 4. *Medical Jurisprudence, Etc.*—T. J. Bennett, Austin, Chairman; F. S. White, Terrell, Secretary. 5. *Gynæcology*—R. R. Walker, Paris, Chairman; S. B. Kirkpatrick, Commerce, Secretary. 6. *State Medicine, Etc.*—I. M. Cline, Galveston, Chairman; Joseph A. Mullen, Houston, Secretary. 7. *Ophthalmology, Etc.*—Vard H. Hulen, Galveston, Chairman; R. F. Miller, Sherman, Secretary. 8. *Dermatology, Etc.*—Geo. H. Lee, Galveston, Chairman; W. M. Yater, Grandview, Secretary. 9. *Microscopy, Etc.*—W. R. Blailock, McGregor, Chairman; W. F. Starley, Jr., Galveston, Secretary.

TRANSPORTATION.

The railroads generally offer a rate of one and a third fare on the certificate plan. Mr. C. E. Williams, ticket agent of the Texas & Pacific Railway, has been appointed joint agent to stamp certificates. Delegates should secure certificates from agent at point of departure, which must be signed by Dr. H. A. West and stamped as above, before they can be used to secure reduction on the return trip.

HOTEL RATES.

Ample hotel accommodations are available. Rates as follows: Lamar, \$2.00; Kimball, \$1.00; Buckner, \$1.25; Mrs. Tyler's, \$1.25; Mrs. Jones', \$1.25.

PRELIMINARY PROGRAM.

The session will begin Tuesday morning, April 27th, at 11:30 A. M., at the City Hall. Members are requested to assemble earlier, say at 9 A. M., so as to register as far as possible before the opening. Applicants for membership will sign blank form, giving post-office address and county. Applicants not present may be admitted upon presentation of certificate signed by president and secretary of county or district society. Such certificates will also be received as evidence of graduation from those who apply in person. Applicants who are not members of societies in affiliation with the State Association, will have to exhibit diploma or other satisfactory evidence of graduation. The initiation fee has been abrogated. The annual fee is \$5.00, which amount must accompany the application. Members will receive badges when they register. All are requested to register promptly. The titles of papers appearing in this program having been received in time for proper order, will take precedence of those offered subsequently.

ORDER OF EXERCISES.

Call to order by Chairman Committee of Arrangements, R. R. Walker, of Paris. Invocation, Rev. G. A. Farris. Welcome by Mayor of Paris. Welcome, representing citizens of Paris, A. P. Dahomey, Esq. Welcome, representing Lamar County Medical Association, L. P. McCus-tion, of Paris; response by the President, J. C. Loggins, of Ennis. Roll call. Reading minutes of previous meeting. Secretary's Annual Report, H. A. West. Treasurer's Annual Report, J. Larendon. President's Annual Message and Recommendations, J. C. Loggins.

The President's Address and the Annual Oration will be delivered on Thursday evening, April 29th, at 8 o'clock, after which there will be a reception tendered by the medical profession of Lamar county, this being the only social function authorized by the Committee of Arrangements.

SECTIONS.

Morning Session, 9 o'clock. Afternoon, 2:30 o'clock.

GENERAL MEDICINE.

1. Report of the Chairman. A Resumé of the Advances in Medicine for the Past Year: Lawrence Ashton, Dallas.
2. Dengue: H. A. West, Galveston.
3. The Rational Medical Treatment of Anthrax: T. C. Osborn, Cleburne.
4. Croupous Pneumonia: C. O. Matthews, Terrell.
5. Diffuse Dermatitis Following Infiltration Anæsthesia: Joseph Meyer, Paris.
6. Several Unusual Symptoms Following Cocaine Poisoning: T. W. Conerly, San Angelo.
7. Typhoid Fever of Texas: D. Dupre, Dallas.
8. Typhoid Fever: W. L. Robinson, Danville, Va.
9. Heart Disease: P. S. Roy, Washington, D. C.

SURGERY.

1. Report of Chairman: Bacon Saunders, Fort Worth.
2. Some Remarks Upon the Surgery of the Gall Bladder: Geo. W. Cale, St. Louis, Mo.
3. Re-Section of Inferior Maxillary Bone, with Report of Two Cases: A. C. Scott, Temple.
4. Traumatic Injuries of the Nerves: M. D. Knox, Hillsboro.
5. Talipes Varus, with Report of a Case: F. E. Haynes, Abilene.
6. Surgical Operation in the Nose by New Improved Methods: W. F. Cole, Waco.
7. Surgery of the Arteries: Brad Fowler, Brownwood.
8. Enterolithiasis, with Report of a Case: J. E. Neathery, Van Alstyne.
9. Gun Shot Wounds; Two Unique Cases: J. T. Benbrook, Rockwall.
10. Abdominal Surgery: Thomas W. Wiley, McKinney.
11. Carbuncle: A. O. Scarborough, Snyder.
12. Operative Procedure for Bowel Obstruction, with Case: A. N. Denton, Austin.
13. Adenoid Vegetation in the Vault of the Pharynx, and Its Treatment: Frank D. Boyd, Fort Worth.
14. Perineal Section: Jos. Meyer, Paris.
15. Indication for an Enucleation: Jno. O. McReynolds, Dallas.

GYNÆCOLOGY.

1. Report of Chairman. Prophylactic Gynæcology: R. R. Walker, Paris.
2. Pelvic Inflammations, Etiology: H. K. Leake, Dallas. Causes, Prevention, and Diagnosis: F. D. Thompson, Fort Worth. Pathology: J. T. Jelks, Hot Springs, Ark. Methods of Diagnosis: J. M. Cable, Dallas. Treatment: S. F. King, Sherman. Discussion opened by J. T. Jelks, Hot Springs, Ark.
3. Disorders of the Mind as Relating to Pelvic Diseases: C. M. Rosser, Dallas.
4. Treatment of Abortions: W. H. Monday, Terrell.
5. Management of Gynæcological Cases by the Country Practitioner: J. M. Inge, Denton.
6. Subject Unannounced: Joseph Meyer, Paris.
7. Hysterectomy, Report of Cases: B. F. Kingsley, San Antonio.
8. Ectopic Gestation; Causes, Diagnosis, and Treatment: T. A. Stoddard, Pueblo, Colorado.
9. Puerperal Sepsis: C. C. Walker, Gainesville.
10. Why Do Women Suffer? A. E. McMahan, Marshall.
11. Cure of Cancer of the Uterus, with Presentation of Specimens: Emory Lanphear, St. Louis, Mo.

OPHTHALMOLOGY, OTOTOLOGY, ETC.

1. Report of Chairman: Vard H. Hulén, Galveston.
2. Optic Neuritis: R. H. Chilton, Dallas. Discussion opened by R. E. Moss, San Antonio.
3. Foreign Bodies in the Eye and Their Removal: E. P. Daviss, Houston. Discussion opened by J. O. McReynolds, Dallas.
4. The Use of the Actual Cautery in Hypopion Keratitis: W. R. Thompson, Fort Worth. Discussion opened by H. L. Hilgartner, Austin.
5. Antiseptic Technique of Cataract Operation: J. A. Mullen, Houston. Discussion opened by G. P. Hall, Galveston.
6. Scleritis and Episcleritis: J. O. McReynolds, Dallas. Discussion opened by J. A. Mullen, Houston.
7. The Oculist and the Code of Ethics: R. F. Miller, Sherman. Discussion opened by R. H. Chilton, Dallas.
8. The Toilet of the Injured Eye: S. J. Terrell, Dallas. Discussion opened by E. P. Davis, Houston.
9. Corneal Ulcers: R. E. Moss, San Antonio. Discussion opened by F. D. Boyd, Fort Worth.
10. Hyperæsthetic Rhinitis: J. A. Mullen,

Houston. Discussion opened by W. R. Thompson, Fort Worth. 11. Eye Strain as a Causative Factor in Diseases of the Eyelids: G. P. Hall, Galveston. Discussion opened by R. F. Miller, Sherman. 12. Chronic Naso-Pharyngeal Catarrh: F. D. Boyd, Fort Worth. Discussion opened by W. F. Cole, Waco. 13. The Otologist's Bete Noir—Tinnitus Aurium: Vard H. Hulen, Galveston. 14. Thrombosis of the Lateral Sinus: B. F. Church, Dallas.

The indications are favorable for a large attendance at Paris. The above list of papers guarantees an interesting and instructive session.

If the bill now pending in the legislature, regulating the practice of medicine in Texas, is enacted, the State Medical Association will be called upon to nominate certain members of the examining board.

The Committee of Arrangements have made every necessary preparation. The attendance and co-operation of every regular and reputable physician in the State is urgently solicited. County and district societies wishing affiliation with the State Association are requested to send representatives with a report of officers and membership.

H. A. WEST, *Secretary.*

PUBLISHER'S DESK.

Eureka Springs, Northwest Arkansas.—This famous health and pleasure resort is located in the heart of the Ozark Mountains. Climate mild and bracing. Scenery wild and beautiful. Waters unequalled for purity and medicinal qualities. The Crescent Hotel is now open. Rates reasonable. Excursion tickets on sale all the year. Through sleepers via St. L. & S. F. R. R. Write to Geo. T. Nicholson, G. P. A., 'Frisco Line, St. Louis, Mo., or Manager Crescent Hotel, Eureka Springs, for descriptive pamphlet.

I have prescribed **Bromidia** with pronounced success in several cases of nervousness and restlessness; and in one case of acute cystitis, I have combined Papine with Bromidia, which gave instant relief. Parenthetically, I may say I have personally used a teaspoonful of Bromidia, after having successively lost several nights' rest, and procured a refreshing night's rest, with no bad after-effects. CHAS. E. QUETIL, M. D.

Philadelphia, Pa., February 23, 1897.

Henry's Tri-Iodides exercises a synergistic effect over the entire range of the salicylates and iodides, and is tolerated by the most delicate stomach. Where iodides, potash, soda or ammonia cannot be tolerated, give the iodine alterative, **Henry's Tri-Iodides.**

IN THE PROFESSIONAL EYE

THE AUTHOR OF "BEN BOLT."

Do you remember sweet Alice, Ben Bolt,
Sweet Alice, whose hair was so brown;
Who wept with delight when you gave her a smile,
And trembled with fear at your frown?

In the old churchyard in the valley, Ben Bolt,
In a corner obscure and alone,
They have fitted a slab of the granite so grey,
And Alice lies under the stone.



THOMAS DUNN ENGLISH, AT THE AGE OF SEVENTY.
(Courtesy of the *Midland Monthly*, Des Moines, Iowa.)

Among the many physicians who have wooed and won the muses, a niche must be accorded Thomas Dunn English, the talented author of the sweet song, "Ben Bolt." By the courtesy of the *Midland Monthly* we present

his portrait. Doctor English won his medical degree at the University of Pennsylvania in 1839, and studied law and was admitted to the bar in 1842. Owing to a throat trouble, he was obliged to give up the law and resumed the practice of medicine.

His taste for literature began while he was still in his teens. It was in the *New York Mirror* of September 25, 1843, that "Ben Bolt" appeared. It immediately gained popularity and was copied into many American and English papers, the latter failing to give credit. The authorship of the song has been claimed for others, notably for a German singer named Kneass, who heard it rendered by an English barn-stormer about 1846.

"Ben Bolt" was only an incident in the life of Doctor English. He once had a personal encounter with Edgar Allen Poe, and promptly knocked down the author of "The Raven." The doctor's kindness of heart led him to spend the night nursing his victim. Poe's resentment seems to have gotten the upper hand, for he wrote a scurrilous article on "Thomas Dunn Brown," which appeared in *Godey's Lady's Book*. Doctor English answered this. Poe sued the paper and was awarded \$225.00 damages.

Doctor English is the author of many poems which have appeared in newspapers, in the standard magazines, and in collections of verse. He has been a frequent contributor to medical literature.



Southeastern Missouri Medical Association will meet in Fredericktown, May 4, 5 and 6, 1897. Following is a list of the papers:

1. A Paper, by Dr. O. Haley, Fredericktown, Mo.
2. Pneumonia, L. Hull, M. D., Marquand, Mo.
3. Pneumonia and Its Treatment by Alkaloidal Medication, F. S. Markel, M. D., Allenville, Mo.
4. Report of a Case in Practice, J. A. Van Amburg, M. D., Burfordsville, Mo.
5. Report of a Case, J. J. Norwine, M. D., Bismarck, Mo.
6. Cases in Practice, W. P. Howle, M. D., Oran, Mo.
7. Reports from Practice, Van H. Bond, M. D., Cotton Plant, Mo.
8. Further Notes on a Unique Case, A. D. Blo-meyer, M. D., Cape Girardeau, Mo.
9. The People and the Profession, W. R. Goodykoontz, M. D., Caledonia, Mo.
10. The Progress of Our Science, J. M. Finney, M. D., Leopold, Mo.
11. Puerperal Eclampsia, H. L. Reid, M. D., Charleston, Mo.
12. Chronic Alcoholism, W. N. Howard, M. D., Cape Girardeau, Mo.
13. Diarrhoea of Children, J. L. McGhee, M. D., Williamsville, Mo.
14. Chloroform in Parturition, H. B. Futtrell, M. D., Oak Ridge, Mo.
15. Infant Feeding, Chas. F. Greene, M. D., Poplar Bluff, Mo.
16. Malaria in Its Relation to Diseases of the Eyes, R. W. Baird, M. D., Senath, Mo.
17. Hygiene, as It Should be Practiced in the Country and Smaller Towns, M. Rosenthal, M. D., Kennett, Mo.
18. A Paper, by Dr. F. L. Kieth, Farmington, Mo.
19. What I Don't Know

About Pneumonia, Gavin H. Butler, M. D., Benton, Mo. 20. A Paper, by Dr. J. D. Porterfield, Cape Girardeau, Mo. 21. La Grippe, G. S. Cannon, M. D., Jackson, Mo. 22. Clinic Notes, T. W. Cotton, M. D., Van Buren, Mo. 23. Report of Two Cases: 1st—Complete Obstruction of Nasal Cavity by One Fibroid (Bifid) Tumor; 2nd—Tumor of Right Antrum of Highmore and Nasal Cavity with Obstruction of One Side Only, A. A. Bondurant, M. D., Cairo, Ill.

The officers are: F. Kinsolving, M. D., President, Hornersville, Mo. W. N. Howard, M. D., Vice-President, Cape Girardeau, Mo. A. D. Blomeyer, M. D., Cor. Sec'y, Cape Girardeau, Mo. H. S. McElmurry, M. D., Rec. Sec'y, Charleston, Mo. R. T. Henderson, M. D., Treasurer, Jackson, Mo.

MEDICAL PROGRESS.

The Phonendoscope.—Dr. Manges (New York Academy of Medicine, October 20, 1896,) exhibited the phonendoscope invented by Bianchi. It was modeled after the microphone, and intended as a substitute for the stethoscope. It consists of a small box of hard rubber, closed at the bottom by a diaphragm of ferrotype-plate, and above by a hard rubber cover through which pass the two ear-tubes. A strong metal spring presses against the center of the diaphragm, and against the cover of the box, being muffled at the latter end by rubber. For more accurately localizing the sounds, and for use when auscultation is performed through the clothing of the patient, a metal stem is attached to the diaphragm. Dr. Manges said that its inventor claimed that with its aid one could hear the normal sounds in the muscles and in the viscera. It could be used for all the ordinary purposes in which a stethoscope was employed, but his own experience had been that it offered no special advantage over the ordinary stethoscope in auscultation of the heart and lungs and that it did not fulfill the claims made for it. It was, however, extremely useful in mapping out the limits of the various organs. For this purpose the stem should be placed over the organ to be outlined, and percussion made by stroking the skin lightly in the neighborhood of the instrument. In mapping out air-containing organs the strokes must be lighter than over solid organs or those containing fluid. For abdominal auscultation, including the detection of the foetal heart, it was excellent.—*American Medico-Surgical Bulletin.*

Incontinence of Urine.—Dr. H. B. Carpenter has been using the fluid extract of rhus aromatica with good results in incontinence of urine in children—giving from 2 to 15 drops three times a day. If the urine is acid and high-colored it is well to begin the treatment by giving an alkaline mixture as follows:

Potassium citrate.....	2 drachms;
Spirit of nitrous ether.....	4 fluid drachms;
Simp.....	1 fluid ounce;
Water sufficient to make.....	3 fluid ounces.

Dose—Teaspoonful in water every two to three hours.

In nearly all cases it is wise to add tonics, especially strychnine, to the treatment.—*Philadelphia Polyclinic.*

TRI-ELIXIRIA AS AN OPIUM CURE.

By **Shep A. Rogers, M. D., Professor Anatomy, Memphis Hospital Medical College.**

One of the latest preparations submitted to the medical profession, and one that great claims are made for by its proprietors, has recently come under my observation, and proven all that its proprietors claim.

In view of this latter fact, I have departed from my usual custom, and have decided to record my observations to the medical profession.

Tri-Elixiria claims to be the ideal remedy for "morphinism." This remedy consists of Elixirs of Celery, Hops and Lettuce, the extract of Mandragora, and other drugs known to the profession.

I have had the privilege of watching the treatment of four morphine habitues, which were treated in the following manner by Dr. Brooks, who was making the test. After using Hydrarg. Chlo. Nite., grs. 5, to move the liver, and empty the intestinal canal, Tri-Elixiria was given in teaspoonful doses every two hours, during the hours patient was awake; at the same time the patient's customary allowance of morphine* (which varied in the four cases from 2 to 60 grains daily) was rapidly diminished, so that by the fifth or sixth day they were entirely "off" of morphine. In every case this was accomplished without any pain, restlessness, loss of sleep or appetite on patient's part; in fact, no one would ever imagine that these patients, as they sat around the house conversing, reading, and otherwise amusing themselves in various ways, were passing through what has heretofore been described as the "horrible tortures of a morphine cure;" in fact, they told me (each one of them) that they had at no time during the period of "getting off" suffered any unpleasant effects from the want of morphine, but on the other hand they all said that they felt better from the first day's treatment.

I am sure that they could not have suffered for the want of morphine, as each one of them was given a drachm bottle of the drug and a hypodermic syringe, and allowed to keep it throughout his treatment. This was done under a promise from the patients that in case of suffering they would first apply to Dr. Brooks (the house physician) for morphine, and in the event he failed to give them relief, they were at liberty to use the contents of the bottle in their possession.

In no case did they use any of the supply, each one returning the full amount (60 grains) at the end of his treatment.

I cannot say that in all cases I would advise that the patient have free access to his "best love," as some will, no doubt, fall into temptation, and take "a shot," when they are really not in need of it, but simply through a desire to feel good.

The four cases I mentioned above were selected from a long list of test cases, and in making their selection the object aimed at was to get those whom other "cures" had failed on, and at the same time, cases who really desired to get well, for many morphine habitues have no desire to awaken to the stern realities of life again.

After selecting the cases, as stated above, the next object was to give the remedy a crucial test, which, I think, was done when each patient was given "morphine and a gun."

After carefully watching these cases, I can, unqualifiedly endorse Tri-Elixiria as being the ideal remedy for the opium habit, it being the only cure I have ever seen that takes a patient "off" of morphine without pain, loss of sleep, loss of appetite, and it places him back into the world a normal man, both physically and mentally. It does not leave a shattered nervous condition, aches and pains and other nervous symptoms, so well known to all those who have ever watched a morphine habitue pass through the ordeal of a morphine cure.

In summing up, I must say, that in my opinion, Tri-Elixiria is the ideal remedy for morphinism; in fact, it is the only humane and rational treatment known to the profession. I have witnessed the treatment of a number of patients by the Keeley, and other treatments, and in nearly every instance when they were "off" of the drug, they not only suffered from extreme nervousness, but suffered pains for quite awhile after leaving the sanitarium. Those treated with Tri-Elixiria evinced no such unpleasant after-effects.

TREATMENT OF CHANCROIDS.

By John M. Langsdale, M. D., Kansas City, Missouri.

A neglected chancroid, or an improperly treated one, may, and sometimes does, become the source of distressing complications, while, if taken in time and intelligently treated, it rarely gives trouble of any consequence. It is not my purpose in this short paper to deal with any phase of the chancroid other than the treatment, nor shall I attempt to give the various treatments of different writers, but will confine myself to a brief statement of the treatment which has proven entirely satisfactory in my hands for some time. I do not know how I can better give this treatment than by reporting a few cases from recent practice.

CASE 1.—C. W., male, white, single, aged 28, clerk, consulted me June 8, 1896. General health good. Examination revealed two præputial chancroids; one near the frænum, left side; the other just above this one and separated from it by a narrow margin of healthy tissue. These ulcers were first washed with *hot* water and soap, as well as the balance of the penis, and further cleansed by spraying with peroxide of hydrogen; they were then cocainized and thoroughly cauterized with fuming nitric acid and dressed with campho-phenique powder and gauze prepared with the same drug, when the patient was allowed to go to his work. The after-treatment consisted of cleansing the sores with hot water and peroxide of hydrogen and dressing with the phenique powder and gauze. The sores healed rapidly and completely. No applications, no other treatment.

CASE 2.—J. F., male, white, married, aged 42, agent, came to my office for treatment September 17, 1896. The prepuce was the seat of a large chancroidal ulcer, situated near the dorsum, involving both the dermal and mucous layers. There was a large suppurating bubo in the left inguinal region, which had received no treatment further than the application of tincture of iodine, and latterly flax-seed poultices. The ulcer on

the prepuce was thoroughly cleansed by the use of hot water, scraping and the peroxide of hydrogen spray, after which it was dressed with the phenique powder and gauze. Under thorough aseptic and antiseptic precautions the bubo was now freely incised and emptied, the cavity cleansed with hot water and peroxide of hydrogen and curetted. The wounded surface was covered with the phenique powder and packed with gauze, a bandage applied, and the patient put to bed. The subsequent treatment consisted of thorough cleansing followed by the phenique powder and gauze dressing. Recovery rapid.

The third and last case I shall report is that of M. G., aged 24, male, white, single, clerk, who presented himself for treatment October 3, 1896. Examination showed large chancroidal ulcer on the mucous surface of the prepuce, near the frænum, and a small one situated on the anterior surface of the scrotum. The scrotal chancroid was evidently due to auto-infection, being situated on that part of the scrotum exposed to contact with the pendulous penis. There was an unusual amount of inflammation in connection with these sores, and while the patient could not afford to leave his work, it was thought best to use no cautery. The ulcers were cleansed in the same manner as in Nos. 1 and 2, and dressed with iodoform and iodoform gauze. There was little change for the first four days, but on the fifth day I noticed a dermatitis had developed, covering the front aspect of the scrotum. I at once came to the conclusion that the dermatitis was due to iodoform, as I had seen the same results follow its use before. I substituted phenique powder for the iodoform; the dermatitis soon disappeared and the sores were healed in two weeks. I do not report these cases as unusual or remarkable, for I could report many more like them; but simply to show that they can be treated with absolute certainty of success by the course I pursued in the first two cases, and the latter part of the treatment of the third. I do not hesitate to say that the splendid results in these cases were due to the thorough cleansing of the sores and the free use of the phenique powder. I thought for a long time, as many others do now, that iodoform was indispensable in the treatment of sores of venereal origin, and often forced my patient to submit to its use in spite of his objections, and the suspicion created by its too familiar and disgusting odor. The odor is, however, not the only objection to the use of iodoform, for I have seen some very aggravating conditions follow its use, such as posthitis, balano-posthitis, dermatitis, etc., etc. Experience has convinced me that many times these conditions were due to the iodoform, and not a result of the disease. I have never seen any such complications follow the use of the campho-phenique powder, which is non-irritating, and possesses decided anæsthetic and antiseptic properties, rendering it peculiarly adaptable to the treatment of venereal sores and the resultant inflammatory conditions which may attend them.

CHARLES A. OLIVER, M. D.
1507, LOCUST STREET,
ST. LOUIS, MO.

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., MAY, 1897.

No. 5.

ORIGINAL ARTICLES.

UNITED STATES SURGEONS AS PIONEERS IN ABDOMINAL AND PELVIC SURGERY.*

By A. H. CORDIER, M. D., of Kansas City, Mo.

IN selecting the topic of an address for this occasion, it occurred to me that a paper briefly reviewing the advances in abdominal and pelvic surgery, made by United States surgeons, would be appropriate. I feel my inability to do this subject and the illustrious surgeons justice, as the mere recalling of historical truths, and words of high praise, fall far short of paying the debt of gratitude which the profession and humanity in general owe to these great benefactors for their pioneer work. This debt is indeed great, and can be paid only in installments by those who follow in their footsteps for all time to come. That the surgeons of the United States have advanced this special branch of surgery far more than any other (or every other) nation of the world, no one, who is willing to be convinced, will doubt, after reviewing the operative technique and history of the surgical procedures within the sphere of the abdomen and pelvis.

This life-saving, pain-relieving and comfort-giving army of faithful pioneer workers and investigators, it must be recalled, have, within a few years of our nation's childhood, wrought changes and established surgical procedures far superior to and more numerous than any for centuries prior

* President's Address before the Tri-State Medical Society.

to their time. Much of this work of advancing abdominal and pelvic surgery has been done by surgeons not surrounded by wise and suggesting seniors, not backed by unlimited capital, not sustained by early professional or lay influence, not within easy reach or in command of inexhaustible clinical material, but depending upon their own heartfelt desire to relieve the suffering of an appealing patient they have devised ingenious means, and applied them, skillfully, with most gratifying and lasting results.

It is a remarkable fact that with very few exceptions the operation as perfected by the originator of the procedure has not been improved upon, except in so far as the modern aseptic technique is concerned. It is true that the application or extension of an operation may have been advanced, but as a rule the brand of the original will be seen indelibly stamped beneath the trade-mark of some more recent surgeon who has seen fit to accept the old, but has appropriated it, to the aggrandizement of himself, by naming the operation after its father by adoption. This, however, I am pleased to say, is very rarely the case, and but few instances can be found.

While the wonderful work of the pioneers in abdominal and pelvic surgery is the theme of this short address, it must not be forgotten that many of the major and minor surgical procedures have been advised and first performed by United States surgeons. The name of Brasher, of Kentucky, will ever be remembered as the name of the first to perform a hip-joint amputation. Mott and a host of other general surgeons will ever be associated with pioneer surgical work.

As in all other pursuits, the pathway of the surgeon pioneer has not been strewn with American beauties and other sweet-scented flowers. Progress has always met with many stumbling blocks, but thanks to these conscientious and daring surgeons, who heeded not the jeers of the less progressive, or the threats of the ignorant, but put into execution their well-framed ideas, and demonstrated the correctness of their then advanced views, we have made remarkable advancement.

On December 9 (or 13), 1809, the first ovariectomy was performed by a young and bold Virginian, at that time living in Danville, Kentucky. This great work, inaugurated by McDowell on that date, has saved more lives and relieved more suffering women than all other surgical procedures combined. The outgrowth of his work has been the extension of surgery to other organs in the abdominal and pelvic cavities, and, remarkable as it may seem, the invasion of other abdominal organs by the surgeon has been made principally by the surgeons of the United States.

The work of the abdominal surgeon to-day is accepted as being the height of surgical perfection. Some one has said of McDowell, "He cut away the abdominal barriers, and the surgeons walked in and reaped the harvest of this daring surgical venture."

Dr. Washington L. Atlee, one of the pioneer disciples of McDowell, wrote as late as 1875: "It is well known that from the earliest period of ovariectomy in Philadelphia, down to the present time, it has been my invariable custom to invite members of the profession to witness the operations, in order that they might be able to form a proper opinion of its character, and to judge of its propriety. Many positively refused, and emphatically condemned the innovation, while others took the invitation

as an insult." Very few of the one hundred and ten thousand physicians in the United States to-day would interpose a single objection to being present and endorsing this surgical procedure for the relief of an otherwise fatal malady. Dr. Washington L. Atlee, after reading the reports of McDowell's successes, decided to follow in his footsteps, and during his life performed many successful ovariectomies, and thus forged another link in the golden chain spanning the time from McDowell's work to the work of the modern operators. To Dr. Atlee as a pioneer belongs the praise for establishing ovariectomy as a justifiable procedure. His work in reviving ovariectomy makes him deserving of the highest place.

Dr. Nathan Smith, a native of Massachusetts, in 1821, was the second person to perform ovariectomy, and he did it without a knowledge of Dr. McDowell's operations.

A boldness characterized the work of some of the early pioneers never since surpassed. In 1759, John Bard, of New York, operated for extra-uterine pregnancy, this being the first case operated upon. William Baynham, of Virginia, followed him in 1791, making the second recorded case of ectopic pregnancy operated. This operation fell into disrepute for many years, save in the hands of a few surgeons. The pathology is at this time so thoroughly understood, and the surgical technique so familiar, that it is universally recognized as the only safe way of bringing these cases to a favorable termination. Electro-injection of poisonous drugs has long since been dropped in the management of these cases. To witness the post-mortem of an extra-uterine pregnancy after rupture will be all sufficient to convert the most skeptical that the only safe method of dealing with such cases is the procedure first performed by John Bard.

Robert Battey, of Georgia, was the first to remove normal ovaries "with a view to establish at once the change of life, for the effectual remedy of certain otherwise incurable maladies." This is an operation of undoubted benefit in a special class of selected cases.

J. Marion Sims, a native of North Carolina, after thirteen repeated trials and failures, succeeded in closing a vesico-vaginal fistula, and thereby established an operation for the cure of this most annoying and disagreeable condition. The technique as first practiced by Sims has not been improved upon, and is the operation as practiced to-day with such gratifying results. Sims long anticipated the intestinal work of to-day by advocating the immediate opening of the abdomen, and the repair of any injury to the bowel from gun-shot or stabbed wounds. The suggestion of Sims was first put into execution by a native of our country, Dr. W. T. Bull. (Dr. Kinlock, of North Carolina, it is claimed, performed the first operation known as cœliotomy for gun-shot perforation, in 1863. His patient died.) Dr. Bull's case (1885) is one of the most remarkable laparotomies for gun-shot injury to the intestine. Seven intestinal openings were found and closed. His patient recovered. This very remarkable case was followed, a year or two later, by a very similar one in the practice of the same surgeon.

The work of our fellow (Missouri) statesmen must not be lost sight of along the line of perforative injuries to the bowel.

Drs. Dalton and Bernays have reported a series of almost phenomenal successes following reparative work in gun-shot and stabbed injuries to the hollow viscera of the abdominal cavity. That United States surgeons

have contributed the greater part toward the work of advancing this special class of immediate life-saving work is beyond all question.

We have pioneers to-day, who are members of the Tri-State Medical Society, in the prime of life, actively engaged in practice, whose work as performed to-day will be handed down to posterity along with the work of McDowell, Sims, and others of as great renown.

The surgery of the pancreas has its early history in the work of United States surgeons, and to Senn, of Chicago, most of the credit is due for our present pathological and surgical knowledge of this heretofore obscure organ. Wolcott, of Milwaukee, was the first to remove the kidney (for malignant disease), and is therefore entitled to be enumerated as one of the history-making surgeons of the United States. Hemorrhage of the kidney, from gun-shot and other injuries, is fatal in a large majority of cases, if not treated surgically. This fact being recognized by Keen, he decided to remove the next kidney presenting to him injured, if the bleeding was of a dangerous character, and uncontrolled otherwise.

Keen's first operation was in 1887, the hemorrhage being due to a gun-shot wound.

The technique of abdominal hysterectomy has been made, by our surgeons, as nearly perfect as any operation in surgery. Burnham, in 1853, after making a correct diagnosis, performed the first deliberately planned hysterectomy. Dr. Mary A. Dixon Jones (1887) made an improvement in the technique of this operation by treating the pedicle extra-peritoneally. The work of Eastman has been an influential factor in perfecting the operation of total extirpation, and many operators are using his method altogether.

Kelly, of Baltimore, by his writings and works, has done more than any one to popularize and perfect the technique of hysterorrhaphy, an operation designed to remain in the sphere of legitimate surgical procedures, regardless of the objections raised by a few obstetricians that it results in obstructing labor, and is conducive to miscarriages.

A decade ago the surgery of the intestines was so disastrous that it seemed almost folly to attempt an operation for intestinal obstruction or other pathological conditions requiring a resection or anastomosis. Senn, with the introduction of his decalcified bone plates, so simplified the technique that it gave an impetus to intestinal surgery that has resulted in the saving of thousands. The use of hydrogen gas for the detection of gun-shot and other perforative intestinal injuries, was also first used by Senn. While this method is rarely, if ever, resorted to at this time, its use was the direct route to more exact diagnostic methods, and with the operative indications so plain before the surgeons, a more perfect method of dealing with these cases led to the necessity of devising the technique of to-day.

The ingenious button of Murphy's invention is so safe and so easily applied, that its adoption by the novice, as well as the expert, has brought by far the lowest mortality, and the most nearly permanent good results, of any method of intestinal repair.

The work of Weir, Bull, McBurney, Morris and Morton, names familiar to us all, will ever remain as pathfinders in the pathology and surgery of the appendix.

Dr. Weller Van Hook, of Chicago, was the first surgeon to operate for a perforating typhoid ulcer, since which time the operation has been successfully performed a number of times in this, as well as other countries. Dr. J. C. Wilson, of Philadelphia, early recommended this operation, and McMurtry, of Louisville, and Morton, of Philadelphia, were among the first to successfully perform it.

Ureteral catheterization, while first practiced by Powlick, has been simplified and brought into general use mostly through the work of Dr. Howard Kelly, of Baltimore.

The surgical technique of the pelvic viscera, in the presence of universal adhesions in pyosalpinx and ovarian abscesses, as taught and practiced by Joseph Price, is as nearly perfect as any procedure in the whole domain of surgery. His following to-day, in the United States, is the largest of any surgeon in this country.

Gall-bladder surgery, it must be remembered, had its origin in Indianapolis, and the work of Chicago surgeons in this field has been abreast with other pioneer workers.

By their great work these surgical pathfinders have cleared away the stumbling blocks, and made the way smooth for those who follow in their footsteps.

FURTHER OBSERVATIONS ON LACTOPHENIN.

By DR. GEO. HOWARD THOMPSON, of St. Louis,

Professor Materia Medica in the St. Louis College of Physicians and Surgeons; Member of the St. Louis Academy of Medical and Surgical Sciences.

SINCE the publication of my observations on the therapeutics of lactophenin last winter, I have continued the use of this valuable coal-tar product with increasing satisfaction. This is a definite chemical body, differing from phenacetin, in that lactic acid replaces acetic acid, forming what might be called "phenolactin," had not the discoverer preferred the name "lactophenin." The substitution of lactic acid seems to overcome almost entirely the possibility of cardiac depression or the conversion of hæmoglobin into methæmoglobin, an attribute only too frequently met with in antipyrin, acetanilid and phenacetin. At the same time lactophenin possesses every desirable property of phenacetin, with the additional one that, lacking the usual untoward properties of this body, it may be given, if necessary, in largely increased doses with impunity, and will reduce a hyperpyrexia of nervous origin which resists all other antipyretics. As an analgesic it is equal to the best pain reliever in the materia medica, and may be given with confidence in neuralgia from any cause other than traumatic. Neuralgia is a condition subject to recurrence and should never be relieved by any agent liable to cause a drug habit by repetition. Besides, as an anodyne, morphine is greatly overestimated by the profession, even in the treatment of traumatic and colicky pains. I do not mean to advocate any coal-tar product as an anodyne in this class of pain, because herein is the peculiar

realm of morphine; but any form of neuralgia, whether malarial, rheumatic or dyspeptic, or whatever the cause may be other than traumatism or active inflammation, lactophenin will be found safe and satisfactory. A few recent cases showing the action of this body follow:

Mr. J., a student of medicine; aged 21; well nourished and of good family history; had had several attacks of fever and headache, always ushered in with a violent chill. On three occasions previously I had attended him for this trouble. The first time was three years ago, when, after a few days of physical strain, he had a chill followed by fever of $104\frac{6}{10}$ degrees and severe headache. It being the malarial season, I gave him quinine sulphate, gr. x, and acetanilid, gr. v, every four hours, expecting the fever to decline within two hours. The fever did not decline at all, but three days of rest in bed brought about lysis and recovery. I concluded that the fever was of nervous origin, an upsetting of the balance in the heat-producing center caused by overwork. Subsequent attacks occurred at intervals of six or eight months, being brought about by overwork or mental worry. In these I used no quinine, but confined myself to the coal-tar group in physiological doses, to no effect. The fever was not reduced nor the headache relieved, though I used every four hours a combination of antipyrin, gr. x, and acetanilid, gr. v. This neither reduced the fever or relieved the headache, and the patient recovered by lysis in three or four days, as in previous attacks. Two months ago, just after passing his examinations, he had his last attack of nervous fever. This time I prescribed lactophenin in doses of eight grains every four hours. These producing no apparent result, I shortened the interval to two hours. Then there was pronounced effect. The headache diminished and the patient commenced to perspire one-half hour after the second powder was taken, and the temperature went down to normal and remained at normal for six hours, when a chill warned of the waning of the influence of the medicine. Three more powders of eight grains each were given. One-half hour after the second powder was given the patient perspired and his temperature again returned to normal. The third powder was given two hours later, after which the intervals were again increased to four hours, with the result that the temperature remained at normal. At the end of two days the lactophenin was discontinued, and no recurrence took place either in fever or headache.

The chief point of interest in this case is the obstinacy of the fever, which persistently ranged between 103 and $104\frac{6}{10}$ degrees, uninfluenced by coal-tar products except lactophenin. It might be that unsafe doses would have reduced the fever, but that would hardly justify the experiment where the case is not one of immediate danger.

Mrs. K., aged 24; had two children; no kidney or female trouble. She complained of a stitch pain in the middle of the small of the back whenever she turned her body to the right. The pain had persisted a week, and was so severe as to prevent her from doing ordinary housework. Eight-grain doses of lactophenin every two hours gave relief after the third powder, and in one day the pain was gone. The powders were taken at intervals of four hours for two days longer, and discontinued without any recurrence of pain.

Mrs. M., is a Syrian woman, aged 22; married at the age of 12 and has two children; for the last year living apart from her husband. She

took sick three weeks ago with malarial chills and fever. The fever would be accompanied with severe throbbing headache, which usually lasted twenty-four hours. I was called during one of these attacks, just after the onset. The necessity at this stage was immediate relief of the symptoms. To this end I prescribed lactophenin in eight-grain powders every two hours until the headache declined; then continued at intervals of four hours until bedtime. The second powder had no sooner been taken when the headache ceased, patient perspired and the fever declined not to recur again, as suitable specific treatment was taken which aborted the next malarial manifestation and accomplished the cure.

Dr. R., is a dentist of this city. A few months ago he came into my office cyanosed; temperature, 96°; pulse, dicrotic and scarcely perceptible; breathing, shallow and difficult, and great vital prostration. He laid on my sofa and told me that he had taken two powders of phenacetin, of seven and one-half grains each, in whiskey one hour previously, at half-hour intervals, for neuralgia. He admitted that the neuralgia was gone. An injection, hypodermatically, of atropine sulphate, gr. $\frac{1}{100}$, repeated once at an interval of half an hour, restored his circulation and vitality. On my advice he took lactophenin in doses of eight grains thereafter whenever his neuralgic attacks returned, generally with prompt relief; and though predisposed to untoward effects from coal-tar products, informs me that if necessary he can take three such powders at once without any ulterior action.

These few cases indicate to me a great superiority of lactophenin over phenacetin and other members of the coal-tar group of antipyretics and analgesics.

THE TREATMENT OF CANCER OF THE STOMACH.*

By J. M. G. CARTER, M. A., M. D., Sc. D., Ph. D., of Waukegan, Ill.

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THE treatment of carcinoma of the stomach is a subject of absorbing interest. The beginning of the disease is so insidious, its progress often so deceptive and its termination usually so sudden, that much time and thought have been given by the medical profession to discover means of diagnosis and cure. Studies in the line of diagnosis have been crowned with greater success than those directed to the treatment of this malady. Yet much has been accomplished in the therapeutic field, and we may hope for still more brilliant results since so eminent an authority as Virchow believes it possible that nature may be able to produce spontaneous cures. If nature has a means of producing a cure of cancers under any circumstances, man will yet detect agencies or remedies which can assist nature in her efforts to eradicate these morbid growths.

What rational method can be adopted in the search for such a remedy? It matters not what view of the pathogenesis of cancer we take, we know

* Read by title before the Tri-State Medical Society of Iowa, Illinois and Missouri, April 8, 1897.

that its cure must be accomplished by extermination—(a) extirpation, immediate and total; or (b) by such a reinforcement of the natural reparative forces as will aid in the extermination of these strange, proliferating cells. If any remedy can be found which will strengthen the ultimate cells of the body in their struggle with these destructive processes, without doubt something will be done towards producing a cure of cancer. We may hope, in fact we may confidently expect, that the time is not far distant when the brilliant achievements of physiological chemistry and cellular therapeutics will be crowned by a discovery of such a remedy as is needed in these cases of disease of the ultimate vital elements of the body. Reports have already been made of agents discovered along this line, and to some of them we will refer later.

It may be said that at the present time our knowledge of this subject makes it necessary for us to endeavor to meet the following three indications: 1. The relief of urgent symptoms. 2. The relief of dyspeptic symptoms. 3. Removal of the disease. The object under the first two indications is palliative, under the third curative.

1. The urgent symptoms are (a) pain, (b) vomiting, (c) hæmorrhage, (d) perforation, (e) constipation, (f) diarrhœa.

Pain, vomiting, hæmorrhage and perforation are often so very urgent that an attempt to relieve the patient should be made before search is commenced for the cause of the symptom.

(a) To relieve pain will frequently require the use of morphine and atropine subcutaneously, in doses of $\frac{1}{4}$ grain of the former and $\frac{1}{150}$ of the latter. Sometimes this dose may be combined with hydrobromate of hyosine (grain $\frac{1}{100}$) with great success. The morphine and atropine quiet the pain, and the hyosine allays the nervous symptoms. I have seen this combination produce excellent results in many instances.

Hydrochlorate of cocaine or fluid extract of erythroxyton may be given for a local anodyne effect. The cocaine may be given by the mouth in doses of $\frac{1}{8}$ to 1 grain in pill, the erythroxyton in $\frac{1}{2}$ drachm doses, every three, four or six hours in severe cases.

Antifebrin is recommended by Demiéville. Hoffmann's anodyne has been recommended, and chlorodyne will often give relief. Gelsemium is an excellent remedy for continuous use, and has valuable anodyne and nervine properties. It may be given in the form of tincture in 8 to 15 minim doses four to six times a day. Riess claims to have secured excellent results from the prolonged use of condurango. Sometimes lavage with an alkaline solution has given relief. Great caution is required, however, if lavage is attempted in such cases. Usually it is better not to attempt it, especially late in the history of the case. In the early stages 3 to 8 per cent. solution of hydrozone may be used by lavage, or \mathfrak{z} viij of a 2 per cent. solution may be administered once or twice a day. The momentary use of chloroform or ether has been made for excruciating pain, to quiet the patient until other remedies have had time to take effect. Its administration requires caution. The use of atropine and morphine, or some other form of opium with belladonna, will answer the requirements in most cases.

(b) Vomiting is frequently distressing. I use the following mixture in most cases: bismuth s. n., \mathfrak{z} j; oxalate of cerium, \mathfrak{z} ss; in half a glass

of water. Give a teaspoonful every fifteen or thirty minutes, if necessary, but I find it seldom required more frequently than once an hour. The employment of the stomach tube is sometimes very serviceable in these cases, if used with caution. The cold douche or lavage with hot water or alkaline or acidulated water will meet this indication in different cases. Electricity—one pole intra-ventral—frequently gives temporary relief. The electric cautery applied to the epigastrium has been used with a degree of success, but is an unnecessarily severe measure.

(*c*) Hæmorrhage sometimes is alarming and requires active measures. Rest and quiet in bed and the use of ice internally and an ice-bag applied to the epigastrium may be all that is needed. Not unfrequently, however, on account of the profuseness or persistency of the bleeding, it may be advisable to resort to the hypodermic use of ergot, or ergotine. In emergencies I do not hesitate to use thus 15 minims or more of the fluid extract, if I do not have a more suitable preparation at hand.

(*d*) Perforation of the stomach walls is a fatal accident in most, if not in all, cases. Even if death could be delayed by adhesions to adjacent tissues, the stage of the disease in which this misfortune occurs is so near the end that stimulation and, if necessary, anodynes to control pain are about all the measures usually required.

(*e*) Constipation is not so serious as some of the symptoms already mentioned, but may exist throughout the entire course of disease. It is often necessary to give immediate relief. Under such circumstances if an enema of glycerine, warm water or warm soapsuds, salt water, etc., does not cause an evacuation of the bowels, usually it will be found that an enema of a teaspoonful of infusion of senna leaves containing two tablespoonfuls of epsom salts will be entirely satisfactory.

To overcome the tendency to constipation early in the case, the persistent use of cascara sagrada or compound liquorice powder will generally be found sufficient.

(*f*) Diarrhœa frequently occurs in gastric carcinoma and requires attention. If due to irritating fluids or materials passing into the intestine from the stomach, lavage in suitable cases (that is in cases where there is no special contra-indication for the use of the tube) may be sufficient to check the diarrhœa. In general, the removal of the cause will check the discharge. If the cause cannot be determined, the use of bismuth *s. n.* and oxalate of cerium with opium and astringents, especially acetate of lead, may suffice to control this complication. The administration of antiseptics is often all that is needed.

2. The relief of dyspeptic symptoms requires careful regulation of the diet and such assistance to digestion as will in part supply the deficiencies of the gastric secretions in this disease. When it is remembered that hydrochloric acid and pepsin are absent or diminished in quantity in carcinoma of the stomach, it will be understood why we advise that proteids should be given very sparingly as food, or that they should be predigested. In the early stages of the disease, and when the conditions are not known, and when this suggestion is not remembered, nature often comes to the patient's relief by causing a loathing of meat and sometimes of eggs. If these foods are administered without the precaution of predigestion, putrefaction occurs and the gas formed may cause painful distention or annoying eructations.

The use of alkalies and antiseptics will be required, as in other cases of gaseous distention. Nausea and vomiting may occur and must be treated with bismuth, ice and alkalies.

The failure to digest proteids, and their consequent putrefactive decomposition, interferes with the proper digestion of other kinds of food. This interference with the digestion of carbohydrates sets up fermentation and the production of lactic and other organic acids. The fact also that stricture of the pylorus often exists, retaining food a long time in the stomach, will explain another cause of fermentation of farinaceous foods. Hence we must curtail farinaceous diet. If dilatation exist, the food should not be bulky and liquids should be limited. Beneke and others, with the belief that the cancerous growth will thereby be checked, diminish or exclude albuminous or nitrogenous food, and limit such vegetable foods as furnish considerable quantities of phosphates. It must be remembered that a patient may tire of a too limited diet. Extremes must be avoided. I have found a mixed but limited diet to serve the best purpose. Hydrochloric acid, pepsin and papoid may be administered with proteid food, when it is not convenient to predigest it. Milk may be given in many cases, but on account of the deficiency of *rennet* in the stomach it ought to be predigested. Oppolzer makes the statement that patients with gastric cancer vomit less if they take all food cold.

Lavage is frequently necessary to remove refuse material, catarrhal products and other debris before the stomach is in a proper condition for the reception of food. Especially is this needed if dilatation is present.

In the early stages undoubtedly the secretions may be increased by treatment. This may be accomplished by giving the vegetable stomachics and mineral acids. The aromatic sulphuric acid is frequently very valuable. Condurango has been recommended by various authors, and may be used as routine treatment. Lately I have received good results in the beginning of the disease from the use of pilocarpine and electricity—negative pole intra-ventral. Both these agents increase the gastric secretions.

3. Lastly, we consider the curative phase of the treatment. It would be unprofitable to review the history of this subject, and we shall give only the principal remedies used to-day. The use of *hydrozone* may produce a cure in the early stage of the disease.

Virchow approves *chian turpentine*, recommended by John Clay, of London. It is possible that this remedy produces a tendency to degeneration of cells, and if so may attack morbid cells first.

Arsenic is a standard remedy in cancer. It is possible that this agent tends to cause a degeneration of the pathological cells and to stimulate the connective tissue about them to a more vigorous growth. If this is true, the result would be beneficial and the cancer-cells would undergo atrophy. Brissoud thinks two cases in his experience were benefited by *chlorate of sodium*. But the remedy which has had the greatest reputation, especially in Europe, is *condurango*.

Arszewsky and Erichson and others have reported successful cases. Riess has published many cases, in some of which the tumor has disappeared and in others sensibly diminished. It has been suggested that this remedy stimulates the connective tissue to more vigorous growth, this encroaches

upon the cellular elements and a degenerative atrophy results. It must be admitted, however, that the experience of the profession has not maintained the enthusiastic hopes raised by some of these reports. Pilocarpine has been suggested in the belief that it exercises an alterative effect upon the white blood corpuscles. *Nuclein* has recently been brought to the notice of the profession as a remedy which has a powerful nutritive and alterative effect upon the elementary tissues and cellular bodies. I have seen one case where all other remedies seemed to fail in which the administration of this remedy in 5 grain doses four times a day for two months relieved the vomiting, pain and prostration. The case is too recent to determine whether the action of this remedy is permanent. In other cases it has accomplished no apparent good.

In the light of our present knowledge one may resort to any or all of the remedies named, but he should not venture a favorable prognosis, as it must be admitted that few physicians believe a specific has yet been discovered for this disease.

Surgical means have been successful in a few instances, but in the nature of the case the great majority of these patients cannot be treated by surgical interference. With the advances which are being so rapidly made in methods of diagnosis, therapeutics and surgery, the future is pregnant with hope that we may be able ere long to deal successfully with this dreaded disease.

ON CERTAIN INFECTIONS COMMUNICABLE BETWEEN THE TESTES AND PROSTATE IN RELATION TO OCCLUSION OF THE VAS DEFERENS.

By REGINALD HARRISON, F. R. C. S.,
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AS arising out of some operations I have been practicing on the vas deferens, relative more particularly to the relief of certain forms of prostatic hypertrophy, the adoption of this proceeding in other varieties of urinary disease seems worthy of consideration. I refer to certain disorders which are directly communicable from the testis to the prostate above, and thence to other portions of the urinary apparatus, and *vice versa*.

A moment's reflection will call to mind numerous instances where the vas deferens forms the medium for the transference of the bacilli and micro-organisms of certain well-recognized diseases, both in upward and downward directions. Perhaps amongst the most striking is the invasion by tubercle of the several portions of the urinary apparatus from a tubercular nucleus in the testis or epididymis. No less interesting, however, is the passage of various inflammatory products from the prostate and bladder downwards to the testicle or its ducts.

In a certain proportion of cases of urinary tuberculosis it has been shown that the primary seat of infection in the male is either in one or both testes or the epididymis. From these points the infection will spread

along the vasa, eventually affecting in various degrees the whole of the urinary apparatus above. It is on these grounds that the local treatment of the primary infection by castration or by a partial operation on the testis, as by curetting, has been advocated by Rockwell* and others. Instances have occurred where I have been able to watch the dissemination of this phase of tubercular disease. In the first place a deposit, probably scrofulous, has developed after an attack of orchitis or epididymitis; then, after a time, the corresponding vas has been recognized as swollen and knotty, and still later on it has been possible to distinguish minute shot-like bodies in the prostate, on examination of this part by the finger in the rectum. After this stage has been reached, the total disorganization of the urinary apparatus has usually followed as a matter of time. It has been repeatedly urged, and I believe proved, that if excision had been practiced on the primary seat of invasion, infection would have been rendered improbable. I have long recognized the force of this view, but there have been difficulties arising in its application, mainly on the ground that the tubercular element may be already disseminated. I will briefly illustrate my argument:

Three years ago, and shortly after I had published an article† on division of the vas deferens, relative to prostatic hypertrophy, I saw a delicate-looking man with a strong tubercular family history, with a nodule in his left testicle remaining after an acute gonorrhœa. This nodule was deemed to be tubercular, or likely to become so. The question then raised had reference more especially to the removal of this by operation, on the ground of its suspicious nature. The urine was healthy, and so was the opposite testicle and its tubes. Nor was I able to discover any evidence of deposit, so far as the fingers could reach, either in the vas or the prostate. The patient, who had had some medical education, was anxious that either the nodule or the testis should be removed. I did not feel disposed to recommend either course. Having regard to the fact that the disease appeared limited to the nodule, and that any infection would probably pass along the canal of the vas deferens, I proposed to excise a portion of the latter. This was done, and the wound healed in a few days. A year afterwards it was found that the testis and nodule had both completely atrophied. The opposite testicle had enlarged as a consequence of this, and no signs of tubercular infection could be detected. The patient's health and sexual powers were unimpaired.

The second group of cases of transference of infection through these tubes may be illustrated by the inflammations that take place of the testes and tubes, occurring in connection with some cases of prostatic hypertrophy, where catheterism is necessary and often difficult. This is a complication which, when frequently repeated, seriously adds to the gravity and pain of these disorders.

Early last year I saw a gentleman approaching seventy years of age, otherwise in good health, who, in addition to much prostatitis, repeatedly suffered from most painful orchitis in one or both organs, though sexual powers had ceased for some years. He was dependent on the catheter, and these attacks had been going on for some months, almost entirely confining him to bed and preventing him attending to his business. I divided

* *New York Medical Journal*, January 10, 1885.

† *British Medical Journal*, September 23, 1893.

his vasa for him, with great relief so far as his prostatic symptoms generally were concerned. Since this was done he has had no further trouble with his testicles, and this is the point I wish here more particularly to illustrate. Apart entirely from the question as to the effects that vasectomy exercises on the enlarged prostate, there is evidence to show that certain ascending and descending diseases of the urinary organs may be importantly influenced for good by permanent occlusion of one or both of the ducts which connect the urinary with the sexual apparatus.

I have tried various methods for resecting the vas. The simplest appears to consist in exposing the spermatic cord as it joins the scrotum by a linear incision over it about an inch in length. The vas is readily made out and protruded towards the incision by pressure from behind, between the finger and thumb. It can then be easily seized with a pair of Spencer Wells' clamp forceps and brought to the surface, where it is cleaned by a little dissection and a blunt hook or aneurism-needle passed beneath it. A loop is included by a silk ligature, and the free portion removed by scissors. To ligature the duct is insufficient, it being necessary to resect a portion of it. After the loop has thus been removed, the stump is returned with the ligature cut short, and the little wound is then closed with a suture or two. Union usually takes place in the course of a few days. In this way the operation can be performed quickly and almost bloodlessly.

A PLEA FOR THE EARLY RECOGNITION AND OPERATIVE TREATMENT OF CANCER OF THE UTERUS.*

By O. B. CAMPBELL, M. D., of St. Joseph, Mo.,

Professor of Abdominal Surgery in the Central Medical College.

HYSTERECTOMY for cancer of the uterus is now an established surgical procedure, and the success attained is due both to improved technique in operating and as well to the care practiced in arriving at an early diagnosis.

The pathology of cancer of the uterus is not confined to that organ alone, but often involves the lymphatics, the pelvic cellular tissue, and ovaries and Fallopian tubes, the intestines, the bladder and ureters, the vagina and rectum.

The systemic infection occurs quite early in the affection, so that if we hope to successfully eradicate the disease by operative procedures, it is very necessary to make an early diagnosis while the disease is confined chiefly to the uterus. The cervix is very much more frequently the primary site of the development of cancer than the fundus: however, in cancer of the cervix, a granular corporeal endometritis is frequently found to exist, scrapings from which, microscopically, will often reveal the cancer-cell.

This probably accounts for the very frequent recurrence of the disease when the cervix is alone amputated.

* Read before the Tri-State Medical Society of Iowa, Illinois and Missouri, April 7, 1897.

The diagnosis of well-developed cases of cancer of the uterus is easy of accomplishment. The symptoms of hemorrhage, pain, foul-smelling discharges and a developing cachexia, point conclusively to cancer of the uterus. Unfortunately, however, when such a class of symptoms are present, often the pathology is so extensive, and the systemic condition of the patient is such, especially in cancer of the fundus, that surgical treatment is not warrantable.

I can now recall quite a number of cases of cancer of the uterus which have come under my observation during the past ten years, in which the uterus was fixed, the vagina, bladder and rectum in some of them involved, a rise of temperature, pronounced cachexia, and all the characteristic symptoms of cancer of the uterus present.

All of these cases, in my opinion, were unoperable, and all of them died in less than a year after I saw them. In nearly all of them the diagnosis of cancer had not been made, the most of them having been treated for the change of life. In my opinion "the change of life" covers a multitude of sins.

In making an early diagnosis of cancer of the fundus, especially, some very close observation and patient investigation is often necessary. The early symptoms are slight pain, backache, with fullness in the pelvis, with a watery, leucorrhœal discharge, sometimes streaked with blood and a slight hemorrhage often occurring. If occurring during the menstrual life, at the time of the period the flow may be excessive, and the period prolonged, with an occasional hemorrhage during the interim between periods.

Such a class of symptoms could be indicative of several distinct pathological conditions during menstrual life, but in women who have passed the climacteric, such symptoms would be indicative of developing cancer. Cases presenting the clinical features of cancer of the uterus should be curetted and the scrapings examined under the microscope, the clinical changes carefully watched, and if necessary repeated microscopical examination made, until the true character of the affection is proven.

In May, 1896, Mrs. B—, aged 33, consulted me at my office. She complained of backache, a discharge from the vagina and dyspareunia. A physical examination revealed a tender indurated cervix. The anterior lips of the os and cervix were perceptibly enlarged, and a distinct nodule could be felt at the anterior utero-vaginal junction. The os was eroded and a little hemorrhage followed the examination. The depth of the uterus was nearly normal and there was no fixation. A microscopical examination revealed cancer-cells. Kolpo-hysterectomy was performed. It was found necessary to sacrifice considerable vaginal tissue, anterior to the uterus, in order to remove the nodular mass mentioned, so that the bladder was unavoidably wounded. The patient made a speedy recovery with a urinary fistula remaining.

In October, 1896, a woman 49 years of age consulted me for a hemorrhage she had been having for about two months. If she remained quiet the hemorrhage would temporarily cease, to begin again on exertion. She complained of considerable pain and fullness in the pelvis. She was the mother of six children and had never had any uterine trouble. An examination revealed a rather large cervix, a little indurated and pale in color. The uterus was freely movable; its depth five inches. As the sound was made to enter the cervical canal, distinct irregularities could be discerned.

A microscopical examination of scrapings revealed the cancer-cell. Kolpo-hysterectomy was performed, the patient making an uneventful recovery. The morbid anatomy showed marked disease in the entire endometrium, there were several distinct nodules extending into the parenchyma, and the ovaries were nodular.

These cases are given in illustration of an early diagnosis of cancer of the uterus, and should have delay been practiced in either of them in making a diagnosis, operative treatment would have been futile.

I wish here to insist upon the necessity in every case in which there is clinical evidence of cancer of the uterus, that a microscopical examination of scrapings should be made.

When the disease is confined to the uterus, all of the other pelvic tissues being free, we can remove all diseased structures by removing the uterus; while if the disease has involved the lymphatics and other pelvic tissues, some diseased point might escape the notice of the surgeon and a rapid recurrence could be expected.

Cancer is a recurrent affection, and if we hope to cure it in any part of the body we must operate early and remove every particle of the disease. It is no more likely to recurrence when affecting the uterus than any other part of the body.

Our statistics are not very extensive nor definite as to the percentage of recurrences to the number operated upon; however, the immediate mortality need not be great if an early operation is performed, and a large per cent. will remain permanently cured.

In regard to the treatment of cancer, I have nothing new to offer. I consider the vaginal route to be preferable to the abdominal in most cases.

Kolpo-hysterectomy is easy of accomplishment where the uterus is movable. There is less shock, better drainage, and recovery is more speedy.

In advanced cases, where the uterus is not so movable and where there is more or less involvement of adjacent structures, then the abdominal, or the combined abdominal and vaginal, operation would be more certain of accomplishment, and would afford a better opportunity of inspecting the condition of the pelvic tissue. There are a few steps in the operation of Kolpo-hysterectomy that I wish to notice. First, the practice of curetting and packing the uterus with iodoform gauze, and closing the external os with sutures as a precaution against infection of the peritoneal cavity. I believe this to be an unnecessary procedure; the hemorrhage is often considerable and the time lost in its accomplishment is quite a factor.

I prefer to char the cervix and all diseased structures within sight with the cautery, and pack the cervical canal with gauze, which can be accomplished in a minimum amount of time.

Very much time is saved in the use of the clamps for the broad ligaments, and it is never necessary to allow them to remain longer than forty-eight hours. The suturing of the vaginal roof where the ligatures are used upon the broad ligaments, I also consider an unnecessary procedure, and requires some time for its accomplishment. I am convinced that Kolpo-hysterectomy should be performed in all cases of cancer of the cervix, as the remaining stump, after simple amputation of the cervix, furnishes a *nidus* for the recurrence of the disease; and then, in the majority of cases, the existing corporeal endometritis is cancerous in its nature, and the disease is only arrested temporarily.

THE NECESSITY OF SPECIAL INSTITUTIONS FOR THE TREATMENT OF PULMONARY TUBERCULOSIS.*

By A. C. KLEBS, M. D., of Citronelle, Alabama.

PULMONARY TUBERCULOSIS is to us by far the most familiar disease, entering every class of society and depriving it daily of a great number of its members. The best men in the present and in the past are associated with the successful studies of the minutest detail of its etiology and pathology, and it is not said too much, that we know more of pulmonary tuberculosis than of any other disease. Still, the enormous library on the subject, and the lot of medicines and cures employed for its treatment, does in no way alter the fact that we are mastered by the disease. Together with syphilis, tuberculosis not only decimates population but favors the development of a sickly race, which succumbs to the demands of life. Therefore, it is the community which should be the most interested in the struggle for its eradication, from a mere economical standpoint. Since the discoveries in bacteriology, and our better knowledge of the biology of micro-organisms, preventive medicine has become a very important factor in the struggle with infectious diseases. Asepsis and antisepsis are familiar to every one of us, and the prevention of epidemics has received the greatest help. Considering all this, we only must wonder how little, comparatively, is done in this line for the prevention of tuberculosis. The masterly demonstration of its spread by infection, especially developed since the discovery of the specific bacillus, has had the natural consequence of preventive measures with its evident beneficial effects. But the general application of these measures has been much neglected, and it is with great satisfaction that we can see lately energetic efforts in this direction. Why has this taken so long, and why have we practically so little control over this disease? There seem to be chiefly two reasons for these otherwise incomprehensible facts. The one lays in the nature of the disease; in the difficulty of its early recognition; in its slow progress and the mostly insignificant subjective symptoms; further, in the frequent failure of most of the medicinal measures employed in phthisio-therapeutics; the other in the often astonishing lack of knowledge of the etiology and pathology of the disease, and the possibilities of its effective prevention and cure amongst members of the profession.

Often the correct diagnosis is not made at all—sometimes on account of insufficient methods employed, sometimes out of personal considerations. The slow and not very apparent progress invites naturally to mere symptomatic measures—if hygienic rules are prescribed, the physician cannot control if they are carried out, nor will the majority of patients carry them out for a sufficient length of time. Climatic changes, which, of course, only the wealthier can undertake, if they give results at all, often produce no lasting effects, for the mere reason that the patient, after his return, considers himself so well that he enters at once his former mode of life and gradually finds himself in the same condition as before. In any way time is lost which could have been employed much more beneficially.

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As to the second reason, we must sometimes wonder how little appreciated and practically carried out the directions are, which study and experience have given in this disease. The bacillus so often is only regarded as a valuable diagnostic help, often favoring the neglect of exact physical diagnosis. Only few of the patients which came under my care had received directions as to how to dispose of their expectoration. The pessimism in regard to the cure of tuberculosis is a very general one, in spite of all evidences from the dissecting table and the experiences of many physicians. This pessimism has its influence on the public, to whom tuberculosis is one of the most dreaded diseases, and in return induces often the practitioner to spare his patient's feelings on the subject, often just with the opposite effect than intended.

If we consider all these points, we will find that we need practical educational measures on this so important subject. Special chairs for tuberculosis are already occupied in colleges of some States. But the best and most practical schools for the treatment of pulmonary tuberculosis are the special institutions. The sanatoria abroad and the few in this country have already demonstrated to evidence their beneficial influence. Such institutions, provided that they fulfill all requirements, have a beneficial influence, not only by the successful treatment carried out in them, but in a general way more by the training of a stock of patients, which, mingling again with the public, help to propagate the correct ideas about the disease and its prevention and treatment. The great advantage which the sanatorium treatment has over all others is the possibility to supervise the mode of life of the patients. Therefore we have here almost always a guaranty that the prescriptions are carried out. The hygienic-dietetic plan which, in our estimation, shall occupy the first position in the treatment in such institutions necessitates constant supervision. Tuberculous patients are very forgetful and therefore need reminding, even daily. The methods adapted to the individual necessitates an exact knowledge of the patient's physical condition as well as his general disposition; it is evident, of course, that the physician in an institution can facilitate this much easier. Means for exact diagnosis can be employed, which, together with constant observation, permit a clear judgment of the prognosis of the case, and enable the physician to take immediate steps when complications are threatening; the only and most successful way to prevent same. In so many instances patients lose their chance by insufficient knowledge what to do to combat their disease, and mostly doing just what they should not do—taking exercise when absolute rest is necessary; staying indoors when the fresh open air would benefit them; greatly eating unsuitable food, and by that promoting the always threatening digestive disturbances, which, on the other side, are sometimes induced by overdosing of all kinds of medicines. Much valuable time is lost by the patient through the consolation which he got from the diagnosis of "malaria," "bronchial trouble," "chronic cough," etc. The consolation which the patients get through such misleading expressions is soon troubled by steady progress of the disease in spite of all symptomatic medications. The general practitioner sees himself often forced to symptomatic measures, because he is urged by the patient, though he is well aware of its small influence on the constitution. The physician in an institution can do away with all unnecessary

medication and supplant it by natural hygienic means, which, by the necessary prolonged application, is the only rational method. But the greatest benefit to the patients treated in such institutions and to the community in general is insured by the fact that they leave the place well instructed as to how to take care of their expectoration to prevent reinfection or endangering others, that they further know by experience which mode of life is the most suitable to them. As we cannot concede any specific influence on the disease to any climate, though we have to acknowledge its favorable influence, such institutions can be placed anywhere where most needed, provided that they are placed in the country and pleasantly surrounded by attractive scenery. Experience has shown that the treatment succeeds in almost any climate, if there are only provisions for the effective carrying out of hygienic measures. This does away with the necessity of long journeys to the El Dorado, whose praised climatic qualities so often prove deceitful. The cases which are suitable for improvement can be successfully treated near home; those which are too far advanced can be taken care of and the danger diminished which they constantly offer to the community, and there is no doubt that cases which are now regarded by most as entirely hopeless, can be still greatly benefited.

These considerations, as well as the remarkable results of the treatment in such institutions, commands imperatively the attention of everybody. The statistical figures of the morbidity and mortality of this disease demonstrates the necessity that something has to be done and well done. The number of private and public institutions abroad, their already well-proved beneficial influence on the spread and progress of the disease, the well-established system of treatment laid out by men of such great experience as Dettweyler, Penzold and others, invites to the employment of similar measures. In this country it is but lately that the importance of special institutions has produced general interest, and even now personal considerations endanger a general movement in this direction. It is chiefly through the indefatigable efforts of Dr. Trudeau, in the Saranac Sanatorium, that the importance of such institutions has received some attention, but this attention is too limited to create general results. I have no doubt that with the steady progress which we are making in practical medical education, and the greater attention which is given to bacteriology and hygiene, a general movement towards the effective preventive and curative measures of this dreaded disease will be made. There is no country on earth whose political constitution, and whose advancement in all branches of science, favor more the possibility of general measures than this enormous American community, where no narrow-minded considerations hinder the execution of great plans.

It has often been objected to special institutions for tuberculous patients, that just this very association of a greater number of so affected individuals is a danger not only for the patients themselves, but for the immediate surroundings. This objection has become void, since we have conclusive proof that the danger of infection in such institutions, provided they are well equipped and managed, is entirely avoidable, and in every case much less than the one which is constantly threatening in public buildings, hotels, schools, railway depots, in railroad cars, ships,

etc., where the only dangerous fact for infection, the expectoration, is not properly taken care of. The alleged demoralizing effects which the association of more and less advanced cases produces is entirely imaginary, and has been greatly exaggerated. By proper measures a separation of progressing cases can be made possible, especially by the adoption of the cottage plan, which has been introduced by Dr. Trudeau, and has given such excellent results, especially in the treatment of incipient cases. More advanced cases which, as I believe, we have not to consider only from a humanitarian standpoint, have to be treated in such buildings, which facilitate the strictest supervision, by which often results can be obtained where, seemingly, no hope was left. By pleasant surroundings, allowance of entertainment, by useful occupation of patients in the household, as far as this is possible out of doors, in public charitable institutions, by the observation of the improvement in others, the stay in such an institution loses for the patient the disagreeable foretaste of hospital life. The alleged disadvantages are in no way in relation to the great advantages in regard to benefit of the patients themselves, and the spread of healthy and correct ideas about the disease and its control.

It is obvious that in order to get the best possible results in the construction and management, certain requirements have to be strictly fulfilled. Penzold gives in his masterly treatise on the subject the rules which have to be adhered to, in order to fulfill all necessary requirements. His points are: Favorable situation in pure air, protection from winds, near mountains and forests, amidst gardens or parks, hygienic conditions of buildings in respect to situation of rooms, ventilation, heating, etc. Comfortable opportunities for rest (laying) out of doors (special galleries, verandas, balconies for this purpose). Absolute cleanliness, especially in regard to the expectoration; excellent cuisine and dairy. Direction of the institution by an energetic physician, who is well trained in every respect, but especially in phthisio-therapy, and who has absolute personal authority over the patients; well trained assistants—physicians in sufficient numbers and well trained nurses; removal from home surroundings, facilitating the separation by cordial reception, allowance of diversions, etc.; impossibility of all excesses; exclusion of intercurrent complications.

The combination of these different requirements only produces satisfactory and lasting effects. The great number of the various specific cures and remedies, and their often perfectly scientific recommendation, creates the tendency to neglect, which is of almost greater importance than the removal of the bacillus, the systematic and rational treatment of phthisical disposition and constitution. On the other side, these institutions have every facility to give a thorough test to those causal modes of treatment, and they even have the duty to give them a trial, provided they do not create any dangerous bye-effects, which has to be ascertained by careful experiments. Any medications which are liable to produce such bye-effects have to be absolutely excluded as unnecessary, especially their administration *per orem*. Special institutions permit, in the most thorough way, such combination of different therapeutic measures, which are impossible to be carried out to the same extent at home. The nature of the disease demands the most careful consideration of details, both mentally and physically. Much, of course, depends on the capacity of the directing

physician, on his energy and tact. He has to create fullest confidence, become the friend of his patients in sorrow and joy, consoling the despondent, keeping back those going into extremes in diversions, etc. The work, if it shall be carried out properly, demands seriousness, perseverance and energy from those connected with it; but the success and the gratitude of the patients is ample satisfaction.

As to the practical execution of the work of such an institution, I will give you a brief account of the treatment carried out in the sanatorium in Citronelle, Alabama, in an average case. After a thorough examination the general plan of each patient is laid out, and the patient advised as to the necessities and consequences of a systematic treatment, always considering the individuality of the patient. I do not believe in taking away all hope from one too far advanced; this has no sense and is only cruel; but his family, relatives or friends have to know the full truth about the consequences, and a return to home surroundings, with the necessary precautions, is in most cases to be suggested. On the other side, I insist on telling the full truth to those whose condition gives reasonable hope, and in pointing out to them the necessity of the most energetic measures, and the otherwise unfavorable outlook. The patient is then advised to an almost absolute out-of-door life, and constantly reminded of it; if confined to bed, he is removed in his bed or on a cot out of doors on the piazza, immediately adjoining his room. They are further advised as to the amount of the allowed exercises, and we make it a rule not to allow any exercises in febrile cases, and after the fever has decreased or subsided only gradually the patient is allowed to exercise. The exercises consist in walks, light games, etc. The quiet, out-of-door life is greatly favored in our climate by its mildness; patients can sit or lie on the gallery without especially warm clothes on. To those patients who show only a slight elevation of temperature in the afternoon, greater freedom in walks, games, etc., in the morning is allowed. After this general introduction into the treatment and close observation for some time, we begin with the daily hydrotherapeutic applications, which chiefly consist in a cold shower bath in the morning. Every room is fitted out for this purpose, and the directions are given on the previous evening as to the temperature of the bath. Patients get generally very quickly used to these baths and would not like to do without them. The attendants who give the baths have to be thoroughly competent and reliable. I have found this method of hydrotherapy especially adapted to the disease, and would not like to do without it. The hardening and at the same time stimulating effect is remarkable, besides the patient can easily keep it up after his return home, and generally gladly does so. Further, our attention is paid to the proper regulation of diet, and the patient advised in this direction. Almost all patients have to be taught how, what and when to eat, and to avoid relishes and sweets, which are only detrimental to the appetite, which so often lacks. The point of diet is a very important one and is more carefully considered; but it does not lie in the space of this paper to go into every detail.

Besides these general principles, other more special measures are applied: they are favoring of nasal respiration by local treatment, the daily observation of the upper respiratory passages in general, for the mainte-

nance of healthy conditions and the prevention of threatening local complications. By daily inhalations in special apartments of suitable remedies, as creosote, oil of cloves, etc., a disinfection of the air passages and light systematic respiratory gymnastics are effected. As to the causal therapy, we make use now of tuberculocidin, which seems to give the best results without any inconvenience or danger. My personal standpoint in the question of causal therapeutics is that we can come only to a definite conclusion through the results of undisputable animal experiments, and that clinical observation alone can only sustain them. The experiments with tuberculocidin are personally familiar to me, and create a wide outlook. The principle seems to be the correct one. I believe that we can arrive at an antibacterial and immunizing preparation without the passage through the system of an animal, by which process we would be able to effect a much higher potential of active principles. But these are questions which will be answered in the future, and only the bacteriological laboratories can furnish the solution.

In the two winters in which we have carried out the treatment in Citronelle, Alabama, there were treated 31.25 per cent. of the first stage; 32.50 per cent. of the second stage; and 36.25 per cent. of the third stage. Considering this classification from the pathological condition, not from the clinical aspect, the results were:

Disappearance of signs.....	22.50%
Decided objective improvement.....	46.25%
Remained stationary.....	16.25%
Progress of the disease.....	13.50%
Died.....	2.50%
Gained in weight.....	65%
Fever decreased in.....	62.50%
Fever remained stationary in.....	32.50%
Fever increased in.....	5%
Bacilli were absent in last examination in.....	40%

I am well aware that I have not been able to reveal many new facts to you, still I consider it as the duty of every one interested in this work—and everybody should be so—to draw the general attention to these facts and by that to help the execution of such effective measures in the fight with this disease. The outlook for greater appreciation of this necessity is just now a very favorable one, and it is to be hoped that it will become more and more so. The strength of the community in this country has favored all those marvelous accomplishments in such short time, to the astonishment of the whole world. The community will not allow the decrease of this strength by its worst and most deceitful enemy, tuberculosis, and will combat it by united forces in the best direction.

Illinois Medical Society.—The following officers were elected for the ensuing year: President, Dr. T. M. G. Carter, of Waukegan; First Vice-President, Dr. T. J. Pitner, of Jacksonville; Second Vice-President, Dr. J. C. McAnally, of Carbondale; Secretary, Dr. E. W. Weis, of Ottawa; Treasurer, Dr. George N. Kreider, of Springfield.

ELEPHANTIASIS.

By A. H. OHMANN-DUMESNIL, of St. Louis.

ELEPHANTIASIS, Elephantiasis Arabum, or Barbadoes leg (so named on account of its frequent occurrence in the natives of those islands) is a disease of not so infrequent occurrence as some suppose. It is certainly most often observed in the tropics, but in temperate zones it is observed with sufficient frequency to render some familiarity with its appearance of more than ordinary value. This is the more important from the fact that the trouble is not limited to dark-skinned races, in which it is most frequently observed, but also occurs in Caucasians. Nearly all the cases I have had occasion to observe occurred in Caucasians.

The parts whose integument is most frequently involved in the process are the leg (either one or both), the arm, the scrotum, the scrotum and penis, the labia majora and the labia minora, and the clitoris. In both the male and the female the leg is most frequently affected, and, as a result of the affection of the leg, the foot participates in the trouble to quite a marked degree. The scrotum is next in frequency, and after this the scrotum and penis. I have seen the latter alone affected, but it is comparatively rare. On the other hand, elephantiasis of the clitoris occurs more often, and that of the labia is seen from time to time. So far as my experience goes, the affection localized to the arm is not very frequent, and in such cases the hand is invariably involved as well. Some few cases of elephantiasis of the nose, of the lip, of the ear, and of other parts, have been recorded, but they were evidently written by authors who were misled in their diagnosis by the peculiar overgrowth which had taken place, and which was rather of the nature of a hypertrophy of the underlying tissues, and not of the skin itself. Cases of acne rosacea frequently attain such enormous proportions as to be easily mistaken for elephantiasis, as witness the one reported by me in a former number of this Journal.

The predominant characteristic of elephantiasis is a marked increase in size, accompanied by a loss of the normal contour of the part affected. Thus, a leg will show a cylindrical form as large at the ankle as at the thigh, in an old and well-developed case. In one not far developed, it will be as large just about the ankle as in the case shown in Figure 1. In an arm so affected, the forearm will be cylindrical and the arm the same, there being but slight diminution at the flexure of the elbow-joint; and in both, such an enormous size is attained that the joints become immobilized and the patient cannot use those limbs. The weight which the affected parts attain is something enormous. The leg will become so heavy that the patient can drag it about with difficulty only, or be entirely incapable of even doing this. When the scrotum is affected it may reach to the ground, and has been known to weigh eighty or more pounds, necessitating its being carried about in a stout sack suspended from the shoulders; and the same thing has been observed in connection with the labia. Another peculiarity is that when the scrotum alone is affected, the penis is completely hidden in the mass; and when the labia are attacked by elephantiasis, the genital cleft is no longer visible, and the urethra

must be looked for under the enormously enlarged mass. In the case of the disease affecting the hands or feet, the nails of the fingers and of the toes become completely hidden by the mass of hypertrophied tissue around the nail-folds. The characteristics given above are sufficient to lead to a suspicion of the real trouble, but there are others which will make assurance doubly sure, if they be observed.

When elephantiasis has attained its full proportions, or even some time before this occurs, the skin is rough, papillomatous, forming in some cases enormous folds, and is more or less pigmented. The openings of the sebaceous ducts gape wide open, permitting of a rather free escape of sebum. This latter frequently accumulates in thick, elevated crusts, separated from one another as in ichthyosis sebacea, with this exception, that



FIG. 1. Elephantiasis of the Foot in a Man (Caucasian).

fungous-like masses also show themselves, as shown in Figure 1. This accumulation of sebum does not always occur, there being in many instances a tense, glossy appearance of the integument, in others a rather rugous surface, the opening of the duct of each sebaceous gland being not only patulous, but surrounded by a slight elevation. In all cases the lanugo hairs disappear. There appears to be quite an amount of injury to sensation, which in some cases is totally lost. The motor power of a limb which is affected is also considerably impaired; so that, altogether, it may be stated in general terms that a sensible loss of sensory-motor power takes place in elephantiasis.

The first evidence of this trouble which manifests itself is in the form of an attack of erysipelas or of dermatitis. When such a condition occurs

in certain individuals, the lymphatic vessels or spaces also become involved, and eventually a lymph stasis has declared itself. It is not usual for a single attack of erysipelas or dermatitis to bring about such a change, but it is rather the rule for a number of such to recur; and it is a well-known fact that individuals suffering from a number of such attacks are very prone to suffer from new ones. I have known a gentleman who had his right arm attacked by elephantiasis, and he told me that he had always been subject to recurring intervals of erysipelas, at more or less prolonged periods. He never looked upon the matter in a serious light, but he finally succumbed to an attack of erysipelas which involved the same arm and, by continuation of the process, a portion of his back. This debilitated him to such a degree that he finally succumbed. He might have continued for years in comparatively good health, as the elephantiasic growth in his arm, whilst progressive, was very slow.

In the case shown in Figure 1; it had existed for some years. The patient could give no definite history, his observation having been that it had taken years to attain its present dimensions, and that he always had, and at the time of observation still suffered, great pain in the foot and leg. He merely thought that he had had some eruptions, but no satisfactory anamnesis could be made out. He left the hospital before any decided measures could be taken for his improvement.

In the case shown in Figure 2, we have that of a woman, and it is one of more than passing interest. The disease as shown was in a woman who had borne children, and past middle age. According to her account, the trouble had gradually developed, and the size of the leg had progressively increased. The first sign of the trouble was observed after an attack of phlegmasia alba dolens, which is not an uncommon sequela of pregnancy, and one which was formerly dreaded by physicians. In this case, instead of resolution setting in after the birth of the child (and, it may be stated, no active measures were taken in this respect, ending in a normal condition), a blocking up of the lymph-channels occurred. In consequence of this obstruction, a thickening and a hypertrophy of the skin occurred, thus constituting a true elephantiasis. At the time the patient was observed, locomotion could be performed, but with extreme difficulty, the pain in the leg was intense, and the strength was markedly impaired. A comparison of the affected foot and leg with the sound one, as shown in Figure 2, will readily demonstrate the extent to which the disease had progressed. The left foot is well arched, the toes well defined, and the ankle slender. The entire leg was well shaped and of a much better form than is usually found in women of that age. The right foot and leg presented misshapen, enlarged outlines, and apparent lengthening of the whole extremity not actually present. A curious fact in connection with this case was that the ducts of the sebaceous glands were not yet enlarged. The skin was markedly thickened, although no roughness or rugosities were apparent. Only one fold, just above the ankle, attested to the effects of attempted locomotion, and the first impression produced would be that the case was one of a fracture. The indications at this time were that there would most probably be a continuance of the process and extension upwards, unless active measures were taken to arrest it. Like all or nearly all patients in public hospitals, she objected quite strenuously to

any method proposed, and accordingly left the hospital, and has been lost sight of since that time.

As may be surmised from what has been said, the trouble consists essentially in an hypertrophy of the skin, more especially affecting the deeper layers. The corium suffers a marked thickening, the stratum mucosum sharing in this, and the outermost, or stratum corneum, being also affected, somewhat in the same manner. Large lymphatic spaces and hypertrophy of the lymphatic vessels, as well as an increase in their number, may be observed; all of which would tend to support the theory that the disease depends essentially upon an obstruction of lymphatic vessels. Any one who has carefully read Busey's interesting résumé of articles em-



FIG. 2. Elephantiasis of Right Leg in a Woman (Caucasian).

braced in his work on "Obstruction of the Lymph-Channels," will be immediately struck by the truth of this explanation, not only for the origin of elephantiasis, but also for that of many other conditions which, at first glance, have seemingly no connection with one another. The condition now being considered has no connection whatever with lymph varices, lymphangioma, or with a curious condition of dilatation of lymph spaces which I have had occasion to observe in a single instance. The question in connection with the pathogeny of elephantiasis is in regard to the ultimate cause of the peculiar obstruction of the lymph-channels. We are told by competent authority that the *filaria sanguinis hominis* is the true cause bringing on that condition known as filariasis, which is equally

held responsible for hemato-chyluria, a tropical disease of which I find no record of having been seen in this country, and of which I had occasion to note a marked case some years ago.

Whatever the cause may be, there is no question whatever that, after one attack of an obstruction of the lymph-channels, the integument of the involved portion is slightly thickened and remains so. Successive attacks occur, and they invariably involve the locality where the first one appeared and also a portion of the adjacent parts. The thickening of the skin increases until the part which is affected grows to immense, even gigantic, proportions. The density of the skin keeps pace with the increase in size of the part which is subject to the process. I have seen and, in fact, possess pieces of skin more than one and a half inches in thickness, and these were derived from a case which was by no means unusual for its size.

Many interesting cases of this disease have been reported, a certain number being spurious. There are other hypertrophic processes which have been described as elephantiasis, when they really consisted of a simple connective tissue proliferation, accompanied in some instances by an exuberant infiltration of small round cells. The characteristic appearances of the trouble, from a clinical point of view, must never be lost sight of in formulating a diagnosis. For this reason it is not well to rush to radical measures of treatment which might possibly be unnecessary.

This brings us to the important subject of the treatment of the disease, which is far from being easy. It has been advocated by some authors that the use of internal remedies alone is capable of bringing about marked changes for the better, but no authenticated cases of a radical cure have yet been published, so that such suggestions may be held as belonging to that vast category of methods, the results of which have been declared not proven. Iodide of potassium and other alteratives have enjoyed a great reputation in the improvement of these cases, but competent observers have become very much discouraged at the impotence manifested by these drugs, and have completely abandoned such measures. This conclusion has become so firmly rooted in the minds of those who are competent to pass judgment on the disease and who are acquainted with its pathology, that they no longer even counsel or essay the use of drugs for the cure of elephantiasis.

The only eligible methods are really those which are surgical in character. All medicinal measures having failed, an attempt was made by some to envelope an affected limb in a solid elastic rubber bandage; but this failed most signally on account of the excruciating pain produced, which would lead patients to tear the bandage off in their agony; so that a measure which, at first glance, might be deemed efficient and painless, in reality proved itself the most agonizing of any attempted.

Among the more rational procedures which have been adopted with some show of success, is the ligature of the femoral artery or of the brachial artery high up in cases of elephantiasis of the leg and of the arm, respectively. The ligature of the femoral must be made in Scarpa's triangle, so as to cut off as many large branches as possible. So far as the brachial is concerned, it should be tied as high up as possible, it being necessary at times to ligate the axillary. There are quite a number of cases reported as having been successfully treated in this manner. No

definite result is to be anticipated from this procedure, as most serious consequences may result, such as the effects which are apt to set in from an inadequate supply of blood. Gangrene is often the termination of this procedure, and it is very rapid, involving the entire loss of the implicated limb. This is not the only trouble which attends the procedure. Septicemia of a destructive character is apt to set in and, as a result, death takes place. So that, on the whole, ligation of the principal artery cannot be recommended in cases of elephantiasis. A better method might, perhaps, be the ligation of the principal lymphatic vessels; but, of course, this is entirely out of the question. Even if such could be effected it might not prove efficient, on account of the large collateral circulation and the obstruction of the lymph-channels would be still greater, if anything.

A surgical method much superior to the one just mentioned, is that of amputation. The results attained by this procedure are much superior to those obtained by ligation. Prompt and good union of the tissues follows, and, beyond the deformity produced, the patient is comfortable, with little or no probability of the disease occurring anywhere else or affecting any other part. When it is the scrotum which is affected, a different mode of operation is practiced. It may be remarked that scrotal elephantiasis exists alone, no other portion being implicated. A method of decortication and plastic surgery is to be followed, whereby the testicles are not only not injured, but are enclosed in a comparatively thin pouch, and the penis permitted to protrude its whole length. In those cases in which the penis is implicated, decortication may be practiced in some, but in the majority of instances very little can be done. If the weight of the organ becomes too enormous, the only recourse to be had is to amputate, either partially or completely. In the case of the labia minora, the best method is, undoubtedly, complete extirpation, the clitoris being preferably included in the operation. And the reverse holds true. If the clitoris be the part affected, amputation is best, including the labia minora in the operation. In cases of elephantiasis of a labium majus, or of both labia, thorough extirpation is the only operation which will be followed by success.

One method, which is probably destined to become the one finally adopted when it is better known, is electrolysis. Excellent results have been obtained by this means, but so far the length of time required has been an inordinate one, and very few patients are willing to wait for such a long time, even to obtain a perfect result. The best result obtained by this method has been published by Silva Araujo, of Rio Janeiro. The method of procedure is to thrust the needle deep down into the tissues at frequent intervals. The strength of the current should be carefully gauged to avoid destruction of tissues instead of the changes which are brought about by the electrolytic current. In addition to this, if the current be too strong, irritation is apt to be produced, and this increases the very hypertrophic process which it is sought to alleviate or cure.

Elephantiasis is a very interesting condition, its histopathology being especially of more than ordinary interest. Its study has been pursued by many, and is still being prosecuted in order to arrive at a better understanding of the underlying conditions, and determine in this manner better and more adequate means of procuring good results without any attendant mutilation.

FORMULÆ.

Acne.

For external treatment of acne the following lotion is of value:

℞	Sulphur precip.....	̄ iss.
	Pulv. tragacanthæ.....	gr. xx.
	Spir. camph.....	fl ̄ ij.
	Liq. calcis.....	q. s. ad. fl ̄ iv. M.

Or, where the skin is especially oily, the following:

℞	Sulphur præcip.....	̄ iss.
	Etheris.....	fl ̄ iv.
	Alcoholis.....	fl ̄ iiiiss.

M.—*Stelwagon, Coll. and Clin. Rec.*

Rheumatic or Muscular Pains.

℞	Chlor. puræ.....	̄ v.
	Tinct. opii.....	̄
	Acidi salicylici.....	aa ̄ iv.
	Spir. vini rect.....	̄ iv.
	Ol. dulcis.....	q. s. ad. ̄ xij.

M. Sig.: This should be rubbed into the parts thoroughly or applied by means of flannel cloths.—*Manley, Ex.*

Nasal Wash.

J. E. Rhodes, of Chicago, recommends the following antiseptic tablet as a nasal wash, one of them being dissolved in from one-half to two-thirds of a glass of lukewarm water:

℞	Potassium chlorate.....	gr. iiss.
	Sodium bicarbonate.....	gr. x.
	Sodium chloride (C. P.).....	gr. x.
	Sodium salicylate.....	̄
	Sodium biborate.....	aa gr. v.
	Thymol.....	gr. ̄ 18.
	Eucalyptol.....	m. ̄ ¼.

—*Jour. Amer. Med. Asso.*

Spermatorrhœa.

℞	Tinct. cimicifugæ.....	fl ̄ iij.
---	------------------------	-----------

Sig.: Teaspoonful three times a day.—*Morse.*

℞	Potass. brom.....	̄ j.
	Aq.....	q. s. ad. fl ̄ iij.

M. Sig.: Teaspoonful, well diluted, three times a day. (In the strong and plethoric.)—*Bartholow.*

℞	Antipyrin.....	̄ ij.
	Syr. acaciæ.....	fl ̄ ss.
	Aq. cinnam.....	ad. fl ̄ iv.

M. Sig.: One or two dessertspoonfuls at night.—*Thor.*

℞	Tinct. gelsemii.....	fl ̄ ij.
	Tinct. belladon.....	fl ̄ ij.

M. Sig.: Fifteen drops at bedtime.—*Bartholow, Ex.*

Malarial Hæmaturia.

Keep the bowels open with calomel, followed by salts; use hot mustard baths and administer the following combination in alternation every three hours:

℞	Spir. turpent.....	̄ ij.
	Acidi carbol.....	gr. x.
	Pot. chlorat.....	̄ iij.
	Spir. lav. comp.....	̄ ij.
	Acacia gum.....	̄ iij.
	Aq. menth. pip.....	q. s. ad. ̄ iv.

M.—*Long, Louisville Med. Monthly.*

Corns.

The following painted on the corn night and morning for several days, will often afford much relief. At the end of such treatment the corn will, as a rule, come readily away:

℞	Acid salicylici.....	gr. xxx.
	Ext. cannabis ind.....	gr. x.
	Collodii.....	̄ iv.

M.—*Stelwagon, Med. Summary.*

To Prevent Iodism.

It is claimed that the following may be given indefinitely without causing iodism:—

℞	Potass. iodidi.....	̄ iss.
	Ferri et ammon. citratis.....	̄
	Tinct. nucis vom.....	aa ̄ ij.
	Aq.....	̄ iss.
	Tinct. cinchonæ comp.....	̄ ij.

M. Sig.: Teaspoonful three times daily, in water, after meals.—*Sanderson, Medical Weekly.*

TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

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TEXAS AND TEXAS DOCTORS.

It was recently our privilege to attend the meeting of the Texas State Medical Association at Paris. Rarely have we encountered so many genial, whole-souled, intelligent and interesting physicians as on this trip to the Lone Star State. The brethren in Texas have a way of making a stranger feel at home that is very fetching and makes the visitor want to repeat the visit.

Texas is a great State in every respect. She is great in territory: the distance from St. Louis to Paris is about 540 miles: we met several Texans who had journeyed almost as far to attend the meeting, yet had traveled all the distance within the borders of their own State. Texas is great agriculturally. Her rich broad acres of black loam will produce almost anything. Texas is great climatologically, furnishing an endless variety of climates.

Texas is great medically. The papers read at the Paris meeting would reflect credit upon any scientific body. The discussions were able, practical and pointed. Texas has two medical schools: the Medical Department of the State University, located in Galveston; and the Medical School at Fort Worth. Both institutions are doing good work and are in a flourishing condition. Texas has numerous progressive and interesting medical journals.

GOVERNOR STEPHENS REBUKED.

Our intelligent (!) chief executive, who believes in "Osteopathy" and kindred fakes, and is at least three centuries behind the times as far as his knowledge of science is concerned, has been severely rebuked of late. At the recent meeting of the Linton District Medical Society the following resolutions were passed:

WHEREAS, His Excellency, Governor Lon V. Stephens, in the exercise of doubtful and indiscreet power delegated to him by legislative authority, has seen fit to depart from the honorable prestige of his worthy predecessors and displace from the control of the State Lunatic Asylum, No. 1, those whose influence and ability have made the asylum one of the great charities of the West, and placing it under the control of the homœopathic school of medicine, and in the persons of those devoid of experience, illiberal and sectional in science and art;

We, the physicians of the Linton District Medical Society—an organization for the advancement of true and genuine science and in behalf of the common afflictions of humanity—express our regret that the highest officer in the State should lend himself to the infatuation of fractional science, and to the hallucination of unscientific imagery. Wherefore,

Resolved, First: That by this act of the Governor he has forfeited the respect and esteem of all lovers of science and humanity, as well as the impartial citizenship of the State.

Second: That this procedure on his part indicates a mental condition which fails to apprehend the mission of science of rational medicine.

Third: That he fails to appreciate the condition of that unfortunate element in social life who are deprived of their reasoning powers, subjecting them to the management of an inexperienced corps of experimenters who lurk upon his favor for reward.

Fourth: That by this unwarranted innovation upon the helpless occupants of charity of the State, he has prostituted his high office for base purposes and unmanly motives.

Fifth: That we by these proceedings, in the name of science and the interest of our common humanity, do enter our solemn protest against the exercise of power by a bewildered partisan, receiving and holding his office by the suffrage of a free and intelligent people.

Sixth: That this society approves the conduct of Drs. Young and Biggs in refusing to resign their positions except for cause.

The next time "Lonnie" Stephens runs for a State office he will find 6,000 doctors after him with scalping knives. He then can sincerely sing that good old song:

"They're after me, they're after me,
To capture me is their chief desire."

EXAMINE THE PROFESSORS.

We long ago suggested the advisability of having a standard for all who profess to be professors. Knowing that there are men engaged in teaching medicine who cannot spell, and who habitually murder the king's English, we insist that our next Legislature remedy the evil.

In the *Chicago Tribune* for March 8, 1897, Dr. Wm. Brinkerhoff has a letter in which he suggests that the best way to raise the standard of medical education is to require of those who desire to become medical teachers a rigid examination upon the subjects of the medical curriculum.

"Their qualifications to teach should be no less thoroughly tested than are the qualifications of the teachers in our public schools. After examination the aspirant for professional honors should be entitled to a teacher's certificate entitling him to teach for a term of years, as determined by the result of his examinations. Establish the medical professorships upon this basis of 'higher medical education,' then let the diplomas they grant be *prima facie* evidence of competency on the part of the graduate, and there will be no necessity for an examining board.

"The fountain-head made competent and intellectual, the streams of students that annually flow from our medical colleges will be qualified and capable. They will need no law to test their fitness for medical practice. Like begets like."

SOUTHEASTERN MISSOURI MEDICAL ASSOCIATION.

The Twenty-first Annual Meeting of this well-known Society was held at Fredericktown, May 4, 5 and 6. There was a large attendance and many interesting papers were read. Several St. Louis physicians were in attendance, among whom were Doctors McIntyre, Meisenbach and Mooney and ye editor.

Officers were elected for the ensuing year as follows:

Dr. J. P. Sebastian, of Patterson, President; Dr. I. W. Powell, of Holcomb, Vice-President; Dr. M. Rosenthal, of Kennett, Corresponding Secretary; Dr. G. S. Cannon, of Jackson, Recording Secretary; Dr. R. T. Henderson, of Jackson, Treasurer.

The next meeting will be held in Malden, in November.

WEIGHED AND FOUND WANTING.

The Saint Louis Medical Society recently received a report from its special committee appointed to investigate the abuse of medical charity. The report says:

"The committee claims to-night that the greatest corruptor of the profession is the medical colleges, which furnish the greatest, the most injurious number of clinics. What institutions are guilty of the largest number of infractions of the code? From what sources do the most unfriendly acts of the medical profession emanate? The question has been asked, what is the necessity for so many dispensaries unconnected with colleges? So common have they become that the city will soon be designated the city of clinics. The answer is at hand. There is no more necessity for them than any others. They are, however, a good medium for advertising. What is the first thing a doctor does when he comes to town? To connect himself with some clinic or dispensary. Why? Because it pays in advertising, in making acquaintances, in obtaining a clientele.

"Perhaps there is a feeling that some are more guilty than others and that the degrees of sin should be pointed out. In order to place the guilt where it properly belongs, the committee is willing to file this supplementary report, in which they make specific charges against the following named institutions, with a bill of particulars:

"The Mayfield Sanitarium sends posters throughout the country and has an agent that travels in its interests, advertising the principal and his institution.

"The Missouri Baptist Sanitarium has 'free' printed on the signs and cards, with name of superintendent. It has three agents, or runners, that canvass the country, distributing cards or posters, with the names of forty-five of the best doctors in the city. The doctors whose names appear on the dodgers are equally guilty. By what right or justice can this be carried out under the cloak of religion?

"The St. Louis Baptist Hospital distributes dodgers with names of doctors on the medical staff, advertising them as specialists; the Marion Sims College of Medicine is guilty of using the word 'free' on signs and cards and distributing same with the names of the various doctors; the Barnes Medical College is on the list for using the word 'free' in advertising its dispensary; the St. Louis Medical College is guilty of treating applicants free who are able to pay; the Western Polyclinic uses the word 'free' on signs, St. John's Hospital, or Infirmiry, is guilty of issuing and distributing cards with the word 'free', etc.

"The Missouri Medical College is guilty of the greatest breaches of the medical code. It is the greatest offender against the well-being of the medical profession in particular, and the community in general, in treating free patients well able to pay, thereby encouraging pauperism, not only of the laity, but of the doctor. It is bad enough, as outlined in the preceding facts and as stated in the original communication, but the facts are more execrable in this institution, as absolutely no care is taken to weed out the worthy indigent and needy from the well-to-do and rich.

"So long as twenty-five cents is paid by the one and an extra quarter by the other for precedence, the thriving nuisance will continue. The Missouri Medical College is further guilty of using and distributing cards with the word 'free,' and the names of doctors upon them, and having signs with the word 'free' in bold relief."

In our next issue we will print some of the objectionable literature.

Our readers will notice that the two medical colleges which the committee considers the greatest offenders are the St. Louis Medical College (Medical Department of Washington University) and the Missouri Medical College. These are the institutions which have considered themselves among the holy of holies, and above reproach. They have pointed the finger of scorn at others and are themselves found wanting.

The Missouri Baptist Sanitarium, whose agents, according to the committee's report, are engaged in "distributing cards or posters, with names of forty-five of the 'best doctors' in the city," has a medical staff made up almost entirely of professors in the St. Louis Medical College.

The Western Polyclinic is a recent creation which is said to have had its origin in the fertile brain of the editor of the *Medical Mirror*.

St. John's Hospital has a large out-door service, and is said to treat free of charge persons earning good salaries.

We never have been able to understand why a hospital should conduct a dispensary service. Will some one kindly enlighten us? In this connection, we are glad to note that St. Mary's Hospital and the St. Louis Baptist Hospital have abandoned their dispensaries. We hope the Missouri Baptist Sanitarium and the Deaconess' Hospital will do likewise. If there is any good reason for the existence of a free clinic west of Grand avenue we are not aware of it.

After finishing its present work, we hope the St. Louis Medical Society will investigate the advertising quacks within its own ranks.

In conclusion, we believe that the medical profession owes a debt of gratitude to Doctors R. M. Funkhouser, R. H. Finley and P. D. Connolly, who composed the committee.

Missouri State Medical Society.—Following is a list of new officers: President, Jacob Geiger, of St. Joseph; First Vice-President, A. R. Kieffer, of St. Louis; Second Vice-President, U. S. Wright, of Fayette; Third Vice-President, John Punton, of Kansas City; Fourth Vice-President, J. J. Norwine, Bismarck; Fifth Vice-President, J. H. P. Baker, Salisbury; Recording Secretary, J. N. Jackson, Kansas City; Assistant Recording Secretary, B. C. Hyde; Corresponding Secretary, A. F. Dresel, Sedalia; Treasurer, W. E. Evans, Boonville. Next place of meeting Excelsior Springs.

Southern Illinois Medical Association.—The following are the newly elected officers of the Southern Illinois Medical Association for the ensuing year: President, H. C. Mitchell, Carbondale; First Vice-President, C. F. Wilhelmj, East St. Louis; Second Vice-President, W. F. Grimstead, Cairo; Secretary, J. O. DeCourcy, St. Libory; Assistant Secretary, James I. Hale, Alto Pass; Treasurer, L. H. Gault, Sparta. Committee on Necrology, A. M. Lee, Carbondale. Board of Censors, H. V. Ferrell, East St. Louis; C. G. Reagin, Du Quoin; H. R. Guthrie, Sparta; O. B. Ormsby, Murphysboro; J. H. Mitchell, Mt. Vernon.

Fairfield was selected as the place for holding the next meeting, the third week in November.

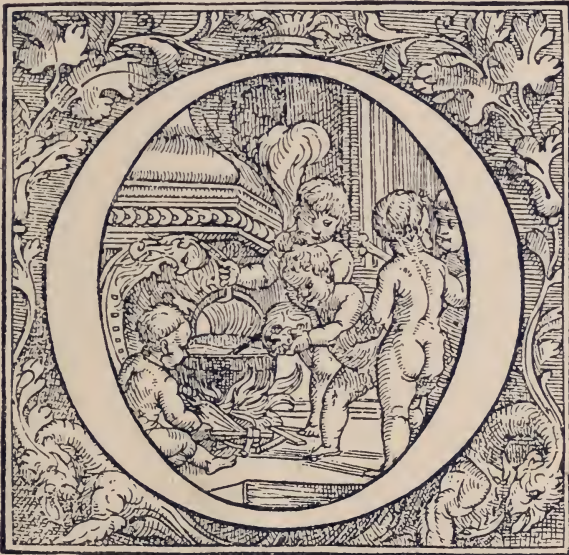
HISTORICAL SKETCH.

THE ANATOMICAL RENAISSANCE.

By JAMES MOORES BALL, M. D., of St. Louis.

II.—ANDREAS VESALIUS (1514-1564), THE GREATEST OF ANATOMISTS.

THE intelligent student of medical history has at his command an un-
failing source of pleasure. To learn the influences which have
brought medicine to its present high plane is his privilege; to search
among ancient, dusty and worm-eaten tomes for facts regarding the great
physicians of antiquity is his delight; and to communicate the knowledge
thus obtained to others less fortunate than himself, who either have not
the facilities or the time for such research, is an undoubted satisfaction.



Initial Letter from the "Anatomy of Vesalius," 1543.

In every period are events and incidents of interest, but to the Middle Ages a peculiar interest attaches. It was during this time that Europe, emerging from an intellectual darkness of ten centuries, awoke to the general Renaissance, and medicine, as has ever been the case, kept pace with the general advance of knowledge. It was in mediæval times that the Anatomical Renaissance was born, grew strong and magnificent, and left posterity a splendid heritage.

The Anatomical Renaissance began with the labors of Mondino, of Bologna, who, in the year 1315, dissected human cadavers in an amphitheater where, for many preceding years, only the bodies of swine and dogs

had been exhibited. Berengarius Carpus, Achillini, Dryander, and others who wrote commentaries upon Mondino's book, added somewhat to the sum of knowledge, but it was by other sixteenth century anatomists that great discoveries were made. Jacobus Sylvius, Carolus Stephanus, Michael Servetus, Realdus Columbus, James Guinterus, John Philip Ingrassias and Gabriel Fallopius are names known in the annals of medical history. A greater man than any of these, however, was Andreas Vesalius.

Andreas Vesalius, of Brussels, young, enthusiastic, courageous and diligent, dared to contradict the authority of Galen, corrected the errors of thirteen centuries, and became the Luther of anatomy. This wonderful young man, before his thirtieth year, had finished the most accurate, complete and best illustrated treatise on anatomy the world had ever seen. Jan Stephan van Calcar, favorite pupil of the renowned Titian, drew the figures from actual dissections. The best engravers cut them in wood to adorn that grand old folio entitled *De Humani Corporis Fabrica*, which was



Ligamenti in Tendibus Continentis Uses. (Vesalius.)

published at Basel in the year 1543. A fortune was lavished upon the illustration and publication of this rare book. Born in 1514, at Brussels, Vesalius was descended from illustrious ancestors. Medicine ran in the veins of the family. "Three weasels formed the family arms of Andreas, whose name was properly Wesalius." Peter Wesalius, the great-great-grandfather of Andreas, was a famous physician; Everard, his grandfather, wrote commentaries upon Hippocrates and Rhazes; and his father was an apothecary to a relative of Charles V. Educated in medicine at Montpellier and Paris, Vesalius at an early age began to teach anatomy at the University of Louvain. So thorough had been his preparatory education that he read the works of Greek and Arab authors in the original. In 1537, in his twenty-second year, he was elected professor of anatomy at Padua. This chair, the first purely anatomical professorship ever instituted, he held for seven years, being at the same time professor at Bologna and Pisa. "The intellectual movement of the northeast of Italy," says M. Renan, "is altogether connected with that of Padua. Now, the universities of Padua and



Lugdun Batavorum Apud

DE VESALII
OPERA OMNIA
ANATOMICA & CHIRURGICA
MDC CXXV.

Edit Vivie et J. & H. Van beek

Anatomical Demonstration, from "De Humani Corporis Fabrica," edition of 1725. (Reduced one-half.)

Bologna were really only one, at least so far as the philosophical and medical instruction was concerned. The same professors migrated nearly every year from one to the other, to obtain an increase in their salaries." Physician to Charles V., after his abdication Vesalius held the same position under Philip II. While living at the Spanish court, he examined the body of a young nobleman who had died under his care. Some ignorant persons who were present at the examination, declared that they saw the heart of the corpse quiver under the knife, and immediately the rumor was spread that Vesalius had committed murder. Prosecuted before the authorities both of Church and State, the anatomist would have been given over to the tender mercies of the Inquisition had not Philip himself interceded. By his influence the impending sentence was commuted to a pilgrimage to Jerusalem, where absolution should be sought at the shrine of the Holy



Initial Letter from "De Humani Corporis Fabrica," 1543.

Sepulcher. The trip was undertaken, the penance performed, and the weary wanderer was hastening homeward to resume his anatomical lectures at Padua, where he was engaged to succeed Fallopius, when he was shipwrecked upon the island of Crete or Zante. Here, in the fiftieth year of his age, the greatest of anatomists perished miserably of hunger.

The anatomical taste of Vesalius was manifested at an early age. When a mere boy he often dissected small animals. In his twentieth year we find him in Paris, where, in company with Servetus, he was prosector to Winter, of Andernach. Of his prosectors Winter speaks in loving terms: "first, Andreas Vesalius, a young man, by Hercules! of singular zeal in the study of anatomy; and second, Michael Villanovanus (Servetus), deeply imbued with learning of every kind, and behind none in his knowledge of Galenical doctrine. With the aid of these two, I have examined the muscles, veins, arteries and nerves of the whole body, and demonstrated them to the

students." His first anatomical work was issued in 1538, and consisted of six plates, which are extremely rare. The figures were drawn by Van Calcar. It is upon the treatise: *De Humani Corporis Fabrica, Libri Septem*, that the fame of Vesalius securely rests. The first edition contained 692 pages, including the index, and was issued from the celebrated press of Joannes Oporinus, at Basel, in the year 1543. The book is a magnificent folio, with elaborate illustrations on wood and many curious initial letters.

The Leyden edition, issued in 1725, shows a beautiful half-length portrait of the great anatomist, who is engaged in dissecting the forearm of a woman. Vesalius is represented as standing by the side of a table, on



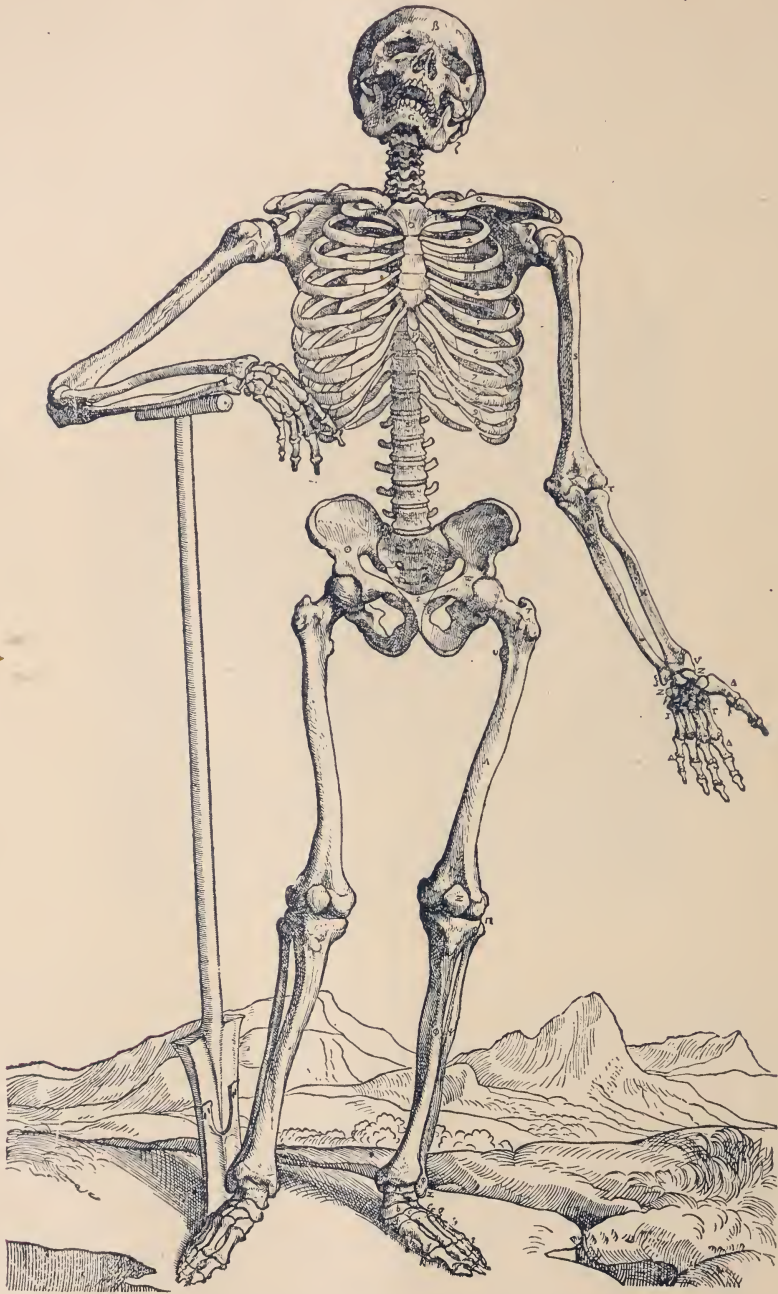
Initial Letter from "De Humani Corporis Fabrica," 1543.

the end of which we find this inscription: An. Aet. XXVIII., MDXLIII., *Ocyus, incunde, et tuto.*

In the body of the work are found those beautiful anatomical illustrations which have served to immortalize both artist and anatomist. Who can realize the toilsome hours spent in dissection, the zeal and diligence of the anatomist, and the anxiety with which he watched the pen of Van Calcar transfer to paper the parts so skillfully separated by the scalpel? And what delight must have filled the soul of Vesalius when the press of Oporinus turned out the last sheets of the "Opus Magnum!" The pictures, for the most part executed with great accuracy, dexterity and taste, represent young, well-developed bodies in freely-bold dissections. The book of Vesalius, both in text and illustrations, revolutionized human anatomy.

For thirteen centuries the world had followed blindly the teachings of Galen, whose knowledge of anatomy was derived from dissection of the lower animals. It was not until the year 1315 that the study of practical human

anatomy was revived. Even then, overawed by the authority of the "divine man," anatomists dared not record the facts they knew. Galen



Skeleton from "De Humani Corporis Fabrica," 1543. (Reduced one-half.)

taught that the septum of the heart was filled with foramina for the passage of blood from one ventricle to the other. Mundinus, the first anatomical

writer after Galen, repeated the error a thousand years later, and a score of servile followers reiterated the falsehood. Berengarius Carpus, in 1521, declared that the openings could be seen only with great difficulty in man (*sed in homine cum maxima difficultate videnter*). In his first edition Vesalius fell into the same pit. In the edition of 1555, however, he states that, influenced by the views of Galen, he believed that the blood passed from the right to the left ventricle of the heart by means of the septal openings. He immediately proceeds to correct the error, and states that the septum is hard, dense, and impervious, and does not permit the passage of blood.

A thorough master of the subject of anatomy, Vesalius was not free from the physiological errors of the age. He does not question Galen's statement of a partial insufficiency of the valves. Blinded by the ancient theory of the movement of the blood—a sort of flux and reflux—Vesalius overlooked the function of the valves in the veins. He described them under the name *ostiola*, as eminences, or projections, or accidental rugosities, interfering in no way with the flux and reflux of the blood. True to the Galenical physiology, Vesalius left the functions of the heart in a no more satisfactory state than he received them.

The anatomical errors which were corrected by Vesalius are too numerous to mention. Almost every page gives testimony to the revolution he effected. He denied the existence of the intermaxillary bone in adults. He said the inferior maxilla did not consist of two pieces, as asserted by Galen. The seven bones of the sternum were reduced by Vesalius to three. He denied that the vena cava takes its origin in the liver. Galen said the bones of the symphysis pubis separate during parturition; Vesalius denied this. He was the first anatomist to describe “the course of the vena azygos and subclavian vein, the ductus venosus, the absence of the rete mirabile in the brain, the five cerebral ventricles, and the non-glandular character of the caruncles, gave a description of the vestibule of the ear, and the long process of the malleus, the tensor tympani muscle, the labyrinth, the sphenoid bone, the mediastinum, the peritoneum and omentum, the cardia and pylorus, the fornix and septum pellucidum, the movements of the brain, etc., etc.—proof enough that he overturned the old anatomy in all points, replaced it with a new science, and even added to the latter new discoveries.”* Vesalius was the first to declare that the anatomy of Galen was based upon dissection, not of the human subject, but of cadavera of the lower animals. For the time in which he lived, Vesalius was remarkably free from errors. Although to him the arteries were carriers of vital spirits, the veins were the true blood vessels, and, according to the first edition of his great book, the septum of the heart was filled with foramina; yet we must say, with Baas, “these are all mere shadows necessary to the brilliancy of the picture.” The city of Brussels, proud of her son, has erected a splendid statue to Vesalius.

The title-page of the book of Vesalius is a grand picture, showing the author engaged in making a public demonstration to a large audience. The place is an anatomical theater, in the center of which we see a female cadaver, with abdomen opened, lying upon the table. The anatomist has raised the index-finger of his left hand, while the right holds a knife. Placed at the head of the table is a human skeleton gazing upward, holding

* Baas: “Outlines of the History of Medicine,” N. Y., 1889, pp. 423, 424.



Second Plate of the Muscles (secunda musculorum tabula), from "De Humani Corporis Fabrica," 1543.
(Reduced one-half.)

a long staff in its right hand. Around are many persons of different rank. To the left, near a window, a naked man is climbing up a pillar, while to the right and below we see a living dog brought into the arena. Above, in the architecture, we see the monogram of the publisher, Oporinus; in the center are the three weasels of the Vesalius family, on a shield whose border bears three pommels; and below is an extravagantly-decorated shield, on which the privilegium is printed. This old engraving is one of the most spirited and elaborate to be found in the whole range of medical literature.

The second edition, issued in 1555, contained 824 pages, and in some respects was an improvement. At later dates editions appeared at Zurich, Lyons, Paris, Venice, Antwerp, Frankfort, Amsterdam and Leyden. The Leyden edition, issued under the supervision of Boerhaave and Albinus, contains reproductions of the original figures engraved upon copper by Jan Wandelaer. Printed in 1725, this edition contains the complete anatomical writings of Vesalius, together with the work on surgery which bears his name. The latter is said by Morley to have been written "by a Venetian, Prosper Bogarucci, a literary crow, who fed himself upon the dead man's reputation." The title-page is similar to that of the edition of 1543, but there are some changes. The monogram of Oporinus has been omitted, and the architecture is somewhat changed. The Figure 4 is a half-size reproduction of the title-page of Vesalius' *Anatomy*, as issued in the Leyden edition. The Vesalian plates have been used to illustrate many anatomical works, both with and without acknowledgment. Thomas Gemini, an engraver and publisher of Leeds, England, cut them in copper, and, in 1545, issued the plates as his own. This is said to have been the first rolling press-work ever done in England. The first edition, dedicated to Henry VIII., was followed by an English translation, in 1552, inscribed to Edward VI. A third edition, printed in 1559, was addressed to Elizabeth.

The College of Physicians and Surgeons, at Chicago, has recently become the medical school of the University of Illinois. Thus, one by one, the creditable medical colleges are attaching themselves to universities. The personal or individual medical school will soon be a tradition.

The Chicago School of Gynæcology and Abdominal Surgery, a Post-Graduate School, will begin its first course June 15. Each course lasts a month and continues throughout the entire year. The object of the school is to give special and practical instruction to physicians in gynæcology, diseases of the abdomen and abdominal surgery during the entire day. It is located at 109 S. Clark street, and has a large and select faculty. Dr. Robinson is founder of the school.

Shine by Comparison.—In the light of recent investigations into the abuse of medical charity in St. Louis, the younger medical colleges present a good showing. The College of Physicians and Surgeons and the Beaumont were unscathed; and the Barnes and Marion-Sims were guilty only of using the word "free" on signs. Compare them with the St. Louis Medical and Missouri Medical Colleges, where hundredsof persons able to pay a physician are treated free!

STUDENT'S MANUAL OF MEDICAL JURISPRUDENCE.

By R. C. BLACKMER, C.M., M.D.,

Professor of Legal Medicine in Barnes Medical College,

CHAPTER XVI.—CONTINUED.

6. The hymen is always situated high in children, and a rape may take place with considerable injury to other parts and the hymen escape rupture.

7. Though the hymen may escape during intercourse, owing to the facts already related, yet labor at full term practically always destroys it.

8. The hymen may persist, after an abortion, before the fœtus has attained any considerable size.

9. The hymen, once destroyed, is never renewed, though inflammatory adhesions between vaginal surfaces may resemble it.

10. There are hymens of every conceivable shape, but the large majority are crescentive in shape and membranous in structure, and situated at the entrance to the vaginal passage and are attended with more or less hemorrhage when ruptured.

11. The hymen may be ruptured by accident or intent early in life.

12. The hymen may be destroyed by ulceration from disease.

13. In forcible intercourse, even without consent between old people, where the man is of weak virile power, and the genitals of the woman relaxed by long continued menstruation or leucorrhœa, the injury is considerably less than between young and active persons with the most free co-operation.

Question. What particular points should be noted when absence of the hymen is alleged as a proof of unchastity?

Answer. 1. Is the vagina dilated or contracted?

2. Are the small rugæ common to virgins present?

3. Are the carunculæ myrtiformæ present?

4. Are there any evidences of delivery, either recent or remote?

5. Are the labia rounded and full, and closely approximated?

6. Are the breasts plump and tight to the body, or flabby and drooping?

7. Are the areolæ pigmented?

8. Is the nipple developed or small?

9. What is the width of the areolæ?

10. Is there any discharge present to account for a relaxed state of the genitals?

11. What is the general moral appearance of the woman?

12. What is the past reputation of the woman?

Question. What questions must be considered when the absence of the hymen is alleged as a proof that rape has been committed?

Answer. 1. Is the rupture recent or remote?

2. Is there a vaginal discharge present?

3. Are there any chancroidal or other ulcers present?

4. Is there any hemorrhage present, or any evidence of any previous to the time of examination?

5. Are there any seminal stains on the clothing?

6. Is there any inflammation of the vaginal or vulval tissues evinced by heat, pain or swelling?

7. Is there any difficulty in separating the thighs?

8. What is the attitude while walking?

9. How long since the alleged defloration took place?

10. Are there present any marks of a struggle?

11. Is the vagina dilated?

12. Was the rupture or dilatation produced by the male organ or by some other instrument?

13. Has there been any recent injury to the posterior commissure?

Question. What are the important points relating to the subject of defloration and chastity?

Answer. 1. While the appearance and conduct of a woman may render any person acquainted with the ways of the world morally certain that she is unchaste, such opinions are intangible in a court of law, and can only be admitted as matters pertaining to reputation.

2. In an adult virgin the vagina is not usually injured at the first intercourse, and in a short time returns to its natural appearance.

3. In a child great injury may be done by the entrance of the adult male organ.

4. When great injury is done, it is much more likely to be the work of the fingers or some other instrument than of the penis.

5. Among the criminal classes in large cities attempts are frequently made by parents and guardians who have young female children in their charge to dilate their genital organs by means of the fingers or some other instrument, such as wooden plugs, knife-handles, clothes-pins, etc., so as to render them capable of prostitution. This is also frequently noticed in India and among savage na-

tions living in close proximity to military stations.

6. If any evidence of importance is to be obtained from an examination, it must be made early, for even in the young, where great injury resulted from the assault, the effects are quickly obliterated by the healing process of nature. It is a frequent occurrence that the persons will not present themselves for examination until long after all signs of injury are gone.

7. It is impossible by examination only to establish the virginity, defloration or chastity of any woman. All evidence thus procured must be confirmed by other testimony.

Question. In what legal complications may the virginity of a woman be called in question?

Answer. 1. In cases of alleged adultery the defense may be set up that the co-respondent named in the case is a virgin, and hence the defendant has never had intercourse with her.

2. In cases of alleged rape the defense may allege that the prosecuting witness is still a virgin, and hence his innocence of the charge.

3. In cases where a suit is brought to set aside a marriage contract, the woman may claim that she is still a virgin and that the marriage has never been consummated.

4. In cases of libel and slander against a woman's chastity she may allege her virginity in public prosecution.

5. A suit of this kind may be brought in defense of a woman's character after she is dead, and an examination may be ordered of her dead body for the purpose of ascertaining the truth in the matter.

[TO BE CONTINUED.]



Diseases of the Eye and Ophthalmoscopy, a Hand-Book for Physicians and Students. By DR. A. EUGEN FICK, University of Zürich. Authorized Translation by ALBERT B. HALE, A. B., M. D. Octavo, pp. xvi-488. Philadelphia, 1896: P. Blakiston, Son & Co.

Although, for the most part, written with accuracy and clearness, this book contains many objectionable features. It may be satisfactory to Swiss students, but cannot pass muster here. Under the head of hypermetropia we find this statement: "Young persons with slight hyperopia (up to 2.00D) can usually see well both near and far objects. They need no treatment." This is not true for America. Under trachoma, excision of the redundant folds of the fornix is mentioned favorably—a plan of treatment now abandoned in this country. Expression of the contents of the follicles by forceps is not mentioned. Gaillard's suture is described for entropium—a procedure now abandoned by its originator. Not a word is said about Snellen's operation, which the writer believes to be probably the best yet devised. In describing the preparation for a cataract extraction, Fick says: "The instruments are taken directly from a *four per cent.* carbolic acid solution and the adherent solution shaken off." Evidently the author means that immersion in a solution of carbolic acid of this strength will render instruments aseptic. This we do not believe. The writer always holds his cataract knives in boiling water. This soon renders resharpening necessary, but it is a reliable method. It is a question, anyway, whether a cataract knife ought to be used more than once before being sent to the factory to be sharpened. The article on latent strabismus is unsatisfactory and does not represent the present state of our knowledge.

The book of Fick cannot be recommended as a text-book for medical students.

The paper is good, the illustrations well cut, and the work is well printed. The colored illustrations are worthy of praise. There are too many typographical errors.

The American Academy of Railway Surgeons.—Report of the Second Annual Meeting held at Chicago, Ill., September 25, 26, 27, 1895. Edited by R. HARVEY REED, M. D., Chicago: American Medical Association Press, 1896.

The American Academy of Railway Surgeons seems to be holding its own, if we are to judge from the excellent papers found in this little volume.

MEDICAL PROGRESS.

Acute Empyema of the Antrum of Highmore—The Question of Self-Healing.—Dr. Casselberry says: “During the last few years the literature of chronic empyema of the antrum of Highmore has been exhaustive and profuse, but little has been said upon the subject of acute empyema; yet this form must be the more frequent of the two. Most of the cases, however, doubtless remain undiagnosed, both by reason of insufficient familiarity with the symptoms on the part of the profession, and also on account of the negligence of patients who, unless the disease is very severe, let it pass as an ordinary acute cold in the head. Dr. Avellis, Frankfort-on-the-Rhine (*Archiv für Laryngol. und Rhinol.*, *bd. IV.*, *heft 2*) describes two grades of acute empyema, the light and the severe form. In a case exemplifying the former variety the patient was examined fourteen days after having contracted a severe cold, great occlusion of the nostrils having developed six days after exposure. On examination a streak of pus could be seen crossing the median line of the septum above the inferior turbinated body, and upon washing out the antrum through a perforation made in the inferior meatus pus was obtained. There was no pain in the region of the antrum—only an uncomfortable pressure in the nose. The patient recovered spontaneously in the course of from two to three months. In this case influenza seemed to bear no etiological relation to the empyema, although influenza is a common cause of acute inflammation of the antrum. The characteristic symptoms of the light form include pain upon pressure and a sense of tension within the upper jaw, and an irregular, purulent, oftentimes bloody, discharge. The pain is intensified by sudden movements of the head, cough, etc. Ofttimes there arise slight edematous swellings of the cheek and eyelid; sometimes the edematous part is reddened. Supra-orbital pain is rare. A foul odor may or may not be present.

“The severe form of the disease presents all of these symptoms, and in addition others of greater gravity, as related in the case of a patient, a physician, who became ill with influenza, suffering from dizziness, vomiting, loss of appetite, cold in the head, headache and backache. Six days later he had a severe pain in the left upper jaw, which was transmitted to the top of the nose and to the forehead, and which gradually increased until the patient was confined to bed. There was tenderness on pressure over the antrum and upon the ball of the eye, with the sense of smell suspended and a profuse discharge of pus. The temperature varied in the evening from 101° to 102°. The author calls special attention to the edematous swelling of the cheek and of the eyelid, which varies in extent, but is to some degree nearly always present, and which is a valuable diagnostic sign. A few days later the patient became delirious and his speech incoherent, the end of a sentence being frequently forgotten. The examination was made about two weeks from the beginning of the affection. Both sides then seemed to be involved, and the diagnosis was rendered certain by a puncture through the inferior meatus upon both sides, when pus was ob-

tained by syringing. There followed immediately thereafter mitigation of the symptoms, and in the course of a few weeks the patient had entirely recovered. One antrum was washed out several times, the other once only. In this severe case the evacuation of the pus seemed necessary to recovery. In the lighter forms of the disease, although the author has usually washed out a single time for diagnostic purposes, he thinks recovery will take place spontaneously. In his observation only one case in ten assumes the chronic form."—*Medicine*.

Bacteriological and Strength Tests of Diphtheria Antitoxic Serum (As reported by Robert L. Pitfield, M. D., Assistant Bacteriologist of the State Board of Health of Pennsylvania, *Public Health*, August, 1896).—A number of samples of diphtheria antitoxic serum were purchased in the open market and submitted to bacteria examinations, both for live bacteria and for the number of antitoxic units reported to be contained in each.

The method of testing pursued, in brief, is as follows: The specified amount of antitoxin, together with toxin (ten times the minimum fatal dose) was injected into a guinea-pig of known weight and good health. This animal was weighed and observed daily until he recovered or died, as the case might be. If it recovered and the antoxin and toxin in proper relative strengths had been injected, the antitoxin was up to advertised strength, if it died the antitoxin was not of strength claimed.

In the following table the results of these experiments are shown. Control animals injected with the minimum fatal dose of toxin alone died in from five to ten days:

A sample of antitoxin said to contain 200 units per cc., made by Behring, was not up to strength.

A sample of antitoxin said to contain 100 units per cc. was up to strength.

A sample of antitoxin said to contain 500 units per cc., made by H. K. Mulford Co., was up to strength.

A sample of antitoxin said to contain 250 units per cc., made by H. K. Mulford Co., was up to strength.

A sample of antitoxin said to contain 100 units per cc., made by Pasteur Institute of New York, was not up to strength.

Are You With Us?—We ask our country subscribers if it is right that they should send cases for treatment to doctors in this city who are known to foster the abuse of medical charity? Can you afford to send students to those colleges where the dispensary doctors habitually treat, free of charge or for a nominal fee, patients well able to pay? Can you afford to patronize a hospital which employs drummers to solicit patients? Are you willing to assist the ethical members of the St. Louis Medical Society in stopping an evil of enormous proportions, and which, if unchecked, will turn a profession into a mere trade?

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter V.—Continued.

TARTAR EMETIC.

Time rolled quietly along; Dr. Newcomer enjoyed the scientific discussions in the medical society; he observed the continuous wranglings, but never participated in them, carefully striving to call no ill-will down on his own head.

During the winter, croup was prevalent. Dr. Newcomer read a paper before the medical society on the treatment of croup with "tartar emetic." A lively debate followed; opinions differed, but tartar emetic was received with general disapproval, in spite of the good results obtained by the author, and still the majority of the members had had no experience with the drug, but they would *not* use it, so that decided the question.

To give tartar emetic its death-blow, one old practitioner, jumping to his feet, exclaimed: "Mr. President, if our young friend had a few more years experience, he would not use tartar emetic, it is too depressing and dangerous. I would not use tartar emetic in a case of croup; I rely upon the compound syrup of squills, it serves me well." There was a general smile at this announcement.

This closed the discussion; no doubt the mind of the President was occupied with compound syrup of squills, as he neglected to give the closing remarks to Dr. Newcomer; but as this gentleman was a young looking member, it called for no comment. In those days the unwritten code was: "Young doctors must treat the veterans with respect, and express no original opinions."

Later, when the old "syrup of squills doctor" learned that Dr. Newcomer had been practicing for fifteen years, he was surprised, and said: "You look so young that I thought you had just graduated."

A PROFESSIONAL CARD.

As time went on, the surgical practice of Dr. Newcomer increased, and eventually he gave up his general practice, and devoted his time and energy exclusively to surgery.

Having previously mentioned his plan to other professors of surgery, a professor of surgery said he thought it a daring venture, but one might *possibly* make a success of it, although it might be without the co-operation of the other physicians; for himself, *he* would not have the courage for such an undertaking, but he would be glad to obtain what general practice Dr. Newcomer might turn away.

Dr. Newcomer was unshaken in his determination; after a certain date he strictly refused all medical cases that called.

In a very short time it was recognized by all that Dr. Newcomer would accept surgical cases only, and as it was something never tried before in St. Louis, it became a legitimate advertisement—refusing one to gain the other.

Dr. Newcomer also sent out cards to the profession, announcing that he practiced surgery exclusively. What a misdemeanor! At the next meeting of the medical society, during "extraordinary business," an adjunct of a professor of surgery arose and said: "Mr. President, I received a card from Dr. Newcomer stating that he practices surgery *exclusively*. This is against the code! It should read 'limits his practice to surgery.' I move this be referred to the Committee on Ethics." The motion was not seconded, and so it was buried, with the lieutenant, under the smiles of the members.

SOCIABLE NEIGHBORS.

It so happened that a well-to-do lady dislocated her shoulder: her family physician, who lived at some distance, was summoned, he referred the case to Dr. Newcomer, who treated the case, reduced the dislocation, and received a good fee.

His colleague to the right said: "That is all right" (the fee). The doctor to the left was doubtful whether the code permitted a regular to accept a patient from a homœopath. The doctor across the street, who heard about the good fee, but forgot the explanation of Clause 1, Art. IV., of the N. C. of M. S., made it his business to go around telling that Dr. Newcomer consulted with homœopaths.

Several months later the same lady took sick and sent for Dr. Newcomer, who declined to go, as he did not practice medicine, and advised the messenger to send for the family physician.

Dr. Rightside, hearing of the lady's illness, approached Dr. Newcomer thus: "Say, you know Mrs. X. is very sick?"

Dr. Newcomer: "Yes, sir."

Dr. Rightside: "Well, I understand that she sent for you, and you did not go. To whom did you refer the case?"

Dr. Newcomer: "To her family physician."

Dr. Rightside: "To a homœopath?"

Dr. Newcomer: "To her family physician, please. I strictly decline medical practice or obstetrics, and if such a case comes to me, I send them to their family physician, who favors me with his surgical cases, no matter what dogma he may follow."

Dr. Rightside: "But I send you my surgical cases."

Dr. Newcomer: "That is all right; I appreciate it. If any of your patients should call upon me for medical treatment, I shall certainly refer them to the family physician."

Dr. Rightside was somewhat disconcerted. He said to take a surgical case was well enough, but to send a patient to a homœopath was wrong and against the code.

It is needless to say that Drs. Rightside and Acrossstreet took special care to impart the news that Dr. Newcomer sent his medical cases to a homœopath. Dr. Leftside was in doubt. He believed in the code, but liked the fee.

PUBLISHER'S DESK.

SEMI-CENTENNIAL MEETING AMERICAN MEDICAL ASSOCIATION,
JUNE 1st, 1897, PHILADELPHIA, PA.

SPECIAL TRAIN, SPECIAL TIME, SPECIAL PLEASURE.

The coming Semi-Centennial meeting of the American Medical Association, to be held in Philadelphia, June 1st to 4th, will undoubtedly be the most interesting meeting of the Association that has been held in recent years; the place of holding the meeting, Philadelphia, the time of the meeting, June, and the programme, all indicate it.

The trip will be a delightful one, and you should begin now to make your arrangements so that nothing shall prevent your going.

In order that a jolly, congenial party may be organized and the trip be made a real pleasure trip, the TRI-STATE MEDICAL JOURNAL has arranged with the Big Four Route and Chesapeake & Ohio Railway to provide as many special sleepers for the exclusive use of the party as may be needed, and also arranged to have them leave St. Louis on the Knickerbocker Special on the Big Four Route at 12.00 noon Sunday, May 30th, and reach Philadelphia next evening at 7.04. This will insure every one from the West and Southwest arriving in time to join the party here.

Arrangements are being made to have the delegations from Indianapolis, Cincinnati, Louisville and other places join us en route, and we will probably have a special train from Cincinnati east. The one-way rate from St. Louis to Philadelphia is \$20.50 via the route we have selected, and we hope to get a rate of one fare for the round trip, but in any event we are sure of a rate of one and a third fare for the round trip on the certificate plan.

The return tickets will be good to leave Philadelphia as late as Tuesday, June 8th, and you will be given the privilege of stopping off at Washington for several days to see the many attractions that the Capital City presents.

The Chesapeake & Ohio Railway is essentially a tourist's route, and it is at its best in the charming month of June. The road is lined with famous health and spring resorts of especial interest to physicians, among which are White Sulphur Springs, the Hot Springs of Virginia, and many others. You can stop off at the Hot Springs on your return trip; it will pay you to see the magnificent new bath houses, the elegant new hotels, and the miles of broad boulevards that have recently been constructed there. The magnificent scenery will charm you, the pure mountain air will invigorate and refresh you, and you will find it a delightful spot.

The Chesapeake & Ohio Railway has been justly christened "The Rhine, the Alps, and the Battle-field Line of America," and the extent and variety of the scenery along the upper Ohio, the great Kanawha, through the cañons of the New River, over the peaks and through the valleys of

the Alleghany and Blue Ridge mountains, and the historic battle-fields of the plains of Virginia, cannot be duplicated in a journey of equal length on any other railroad in America.

The cost of a double berth that will accommodate two people in the through sleeper from St. Louis to Philadelphia will be \$6.00, and we would suggest that you have a berth reserved by sending in your name to Otho F. Ball, Business Manager TRI-STATE MEDICAL JOURNAL, who will arrange for your accommodation on the special sleepers from St. Louis; and if you find that you will be unable to go you can cancel the reservation later. Dr. Ball will cheerfully send you descriptive matter and time tables of the route on application.

The Abuse of Medical Charity.—Of all classes or professions it would seem that physicians are those most myopic, mentally. There is no profession whose members are daily, yes hourly, imposed upon to the same extent. A young man, after due and diligent preparation, studies medicine for four years, gains his degree and begins the practice of medicine, imbued with the idea that it is a *noble profession*. Alas, how soon is the dream dispelled! Many are the persons who could pay the young doctor if they employed him; but it is not necessary to obtain his services. The shrewd layman knows where to go to get excellent treatment for nothing. It has been said that the medical profession is its own worst enemy, and the saying is true. Why any man should study medicine, expecting to secure financial gain from the practice of the profession; is beyond our ken. His very professors, who have been held up to his admiring gaze as paragons of professional purity, are found to be the enemies of the recent graduate. The very leaders of the profession are accomplishing its destruction. There may be some possible reasons for the existence of railway hospitals, where employes can receive treatment at a minimum cost; but what are the reasons for the existence of those free dispensaries and "fifty-cent hospitals," where no distinction is made between the pauper and the person who is able to pay?

The abuse of medical charity has made it almost impossible for a young man in the cities of this country to gain a livelihood by the legitimate practice of medicine.

Oh, consistency! where art thou? The "ethical" and "high-class" doctors who pride themselves upon their "honor," and their "fine breeding," are hand-in-glove with schemes to abuse medical charity.

It is only a question of time when the hospital and dispensary doctors will do all the business, and the rank and file will be driven out of the profession.

Will You Help Us?—We propose to wage an active warfare against the abuse of medical charity. If you are with us, please let us hear from you. This means YOU. If you are not with us, we want to know it.

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Vol. IV.

ST. LOUIS, MO., JUNE, 1897.

No. 6.

ORIGINAL ARTICLES.

ON THE USE AND ABUSE OF ERGOT IN OBSTETRICS.*

By THOMAS MORE MADDEN, M. D., F. R. C. S., Eng.; M. S. O.
Honoris Causa Royal University, Ireland,

Obstetric Physician and Gynæcologist Master Misericordia Hospital; Consultant and Ex-Master National Lying-in-Hospital, Dublin.

THE position of the practitioner who after extended obstetric experience finds himself returning, as I now do, to the discussion of a matter such as the ebolic use of ergot, on which he has previously written, and which long ere he entered the profession or the world had been debated and apparently settled, might at first sight recall the task of Sisyphus, as described by the poet:

“With useless endeavor,
Forever, Forever,
Is Sisyphus rolling
His stone up the mountain.”

Nevertheless, that it is not so superfluous as it would perhaps seem to reconsider this question at the present time can, I think, be easily proved.

In few if any respects are the changes effected since my student-days in obstetric opinion and practice more exemplified than with regard to the

* Abstract of a paper read in Obstetric Section Royal Academy of Medicine, Ireland, April 23, 1897.

employment of ergot and its preparations. At that time this drug was very generally administered, and then too frequently with little discrimination, in the majority of labor cases. A few years later the reaction which was inevitable against such a malpractice set in, and this has continued to operate up to the present period, when the pendulum of professional opinion having now swung back to the opposite extreme, comparative desuetude has replaced the former abuse of the most potent ecboic at our command. That result has been fostered by the teachings of some eminent recent authorities, whose widely accepted views have led to a trend of modern opinion very distinctly and generally adverse to the employment of ergot during parturition. In the following observations I purpose to consider briefly whether the radical change referred to is correct in theory and advantageous in practice or not.

It would appear to me that the objections generally urged against the employment of ergot in midwifery cases, and which are reiterated in several of the manuals now in most favor with students and junior practitioners, are founded on the investigations of Kobert, Faurret and other recent scientists, who in the laboratory have examined the chemical composition of ergot and the physiological action on the lower animals of its several constituents rather than on clinical experience in the lying-in room. As a matter of fact, neither the chemistry of this drug nor the physiological effects of its components are as yet definitely determined. Nor on a question such as this can the mere *dicta*, however authoritative, of scientific inquirers, ever outweigh the actual observation at the bedside of obstetric practitioners. For by many of the latter, and probably by few more largely than myself, preparations of ergot containing, according to Kobert, a toxic constituent of deadly potency in the case of lower animals, have long been employed in daily midwifery practice, without any injurious effect whatever when judiciously used.

The dangers ascribed to the employment of ergot during labor by the writers referred to include: 1st, its possible foeticidal effects; 2nd, the probability of this drug giving rise to such irregular uterine action as to occasion subsequent hour-glass contractions and retention of the placenta; and, 3rd, its direct toxic result on the maternal system. With regard to the first of these objections, the observations of my former colleague, Dr. Denham, and the much more recent remarks of our distinguished president, Dr. Atthill, by both of whom ergot has been given for considerable periods before parturition with safety, supplies sufficient answer. As to the other two reasons which we mentioned or assigned for the non-employment of ergot in labor, I know not how I can more effectually deal with them than by a brief abstract of my clinical notes of a series of 150 cases in which ergot was resorted to by myself, with the reasons for its employment, and the results to mother and child in each instance.

ABSTRACT OF 150 OBSTETRIC CASES IN WHICH ERGOT WAS EMPLOYED BY THE WRITER.—In 70 instances the patients were primipara, in 80 they were multipara. Of the total number 148 recovered and 2 died, viz.: 1 from septicæmia, and the other from typhoid fever which had commenced prior to parturition. In 95 cases ergot was given before the birth of the child, viz.: During the first stage in 15, for persistent inertia of the uterus when (the head presenting) the os uteri was sufficiently dilatable. During

the second stage it was exhibited in 80 cases, either for long delay occasioned by inertia or for the prophylaxis of hemorrhage. In these 95 cases the children were in 92 instances delivered alive by uterine action or by the forceps, and in 3 cases they were still-born. Of the latter, two being putrescent when delivered, no toxic effect could be ascribed to the ecbohic that had been administered during labor. In 86 of these cases the placenta was expelled normally. In 9 its removal had to be assisted, viz.: in 4 for persistent atony of the uterus; in 4 for morbid adhesions, and in 1 for irregular or hour-glass contraction. In 55 cases the ergot was given during or after the third stage, either to hasten expulsion of the placenta or for the arrest or prevention of hemorrhage, or subsequently to check after-pains, or, and lastly, to expedite involution of the uterus.

Whilst my experience, some of the results of which have been here summarized, leads to the conclusion that the dangers ascribed to ergot in parturition might be largely attributed to its abuse I have certainly no desire to minimize the injurious effects of that improper use, as when given under unsuitable conditions and in inefficient doses; from both of which I have seen effects disastrous to mother and child. These results, however, cannot be regarded as any argument against the judicious use of this remedy, the circumstances calling for the use of which may be here briefly stated.

CONDITIONS AND CASES IN WHICH ERGOT MAY BE EMPLOYED IN OBSTETRICS.—Under this heading it will be seen that my appreciation of the value of ergot is much larger than is generally held. Judging from the recent literature of the subject, it may not be useless, however, to promise that to use any preparation of this ecbohic safely and efficiently during parturition it is essential: 1st, that the presentation should be natural or cranial; 2d, that there should be no disproportion between the fœtus and mother, nor any physical obstacle to deliverance in the genital tract; 3d, that the os uteri, if not previously fully dilated, should be sufficiently dilatable to allow of speedy delivery by the forceps whenever that becomes necessary; 4th, that in all cases the preparation of ergot employed and the dose and method in which it is given should be such as are calculated to secure the required oxytocic effect as promptly as possible. Subject, then, to the foregoing conditions ergot may be administered either before, during or after the second stage of labor, namely: Before the full expansion of the os, when dilatable, (*a*) in some instances of long delay from uterine inertia, in which there is either evidence of danger to mother or child from protraction of labor; or (*b*) risk of subsequent hemorrhage. During the second stage ergot may be used (*c*) in nearly every case of abnormal delay from inertia of the uterus in which the presentation is natural and the delivery otherwise unimpeded; or (*d*) whenever under these circumstances there is then reason to apprehend risk of post-partum flooding. During the third stage of labor this ecbohic may be exhibited (*e*) to hasten expulsion of placenta when detained by deficiency of uterine action; or (*f*) for the arrest of hemorrhage. After completion of labor, ergot may be resorted to either immediately (*g*) to check or prevent flooding; or subsequently (*h*) to produce such tonic or permanent contraction of the uterus as may seal up the vessels and so lessen the liability to bacteriological invasion or sepsis; or (*i*) for the purpose of expelling

clots and so arresting after-pains; and lastly, and more especially in the case of multipara, (*j*) it may and should as a rule be given to stimulate the muscular contractility of the womb, and thus assist the process of involution.

METHODS OF USING ERGOT IN OBSTETRIC PRACTICE.—With regard to the ecbolic value of the preparations of ergot, and the manner in which they should be employed, there have been almost as many different views expressed as there have been writers on the subject. In my earlier experience in the Rotunda Hospital, either a glycerine solution, such as Lang's, or else an extemporaneous infusion of freshly-powdered ergot were commonly employed. The latter, although troublesome to prepare and nauseous to take, has probably been unsurpassed in ecbolic activity by any of the more elegant preparations by which it has been replaced. Amongst these may be here mentioned ergotin, whether given by Bonjean's formulary or by Burroughs, Weelcome & Co.'s tabloids of ergotin, or of its citrate, also Oppenheimer's ergot, and Richardson's ammoniated tincture of ergot, or else the officinal liquid extract. Of the utility of each and all of these I can speak from experience of their employment in many instances. Whatever preparation be selected should obviously, I may repeat, be given only in appropriate cases, and that administered in sufficiently full and bold doses to produce the required oxytocic effect as promptly as possible, and never in those small, insufficient and frequently-repeated doses that are now advocated, the dangers of which I have before pointed out. For my own part, I must, however, still confess to a possibly antiquated predilection for the older and, as I have found, generally reliable preparation of ergot supplied by the fluid extract of the British pharmacopœia. Of this in suitable cases in midwifery practice I commonly employ at least two drachms in a single dose, to settle well the simultaneous administration of another drachm or, if necessary, two drachms, by deep hypodermic injection in the genital region. When so given, in appropriate cases, in a single dose, I have seldom found ergot fail to operate as an efficient ecbolic. Subsequently, for prevention of sepsis, the arrest of after-pains, or the obviation of subinvolution, intra-puerperal state, it may be given in drachm doses thrice a day until the desired object is attained.

To act thus safely and efficiently in obstetric cases it, however, probably matters little which one of the active preparations of ergot may be selected, provided always—or in conclusion it may be reiterated—that, like all other potent drugs, this remedy be restricted to those cases in which its use is really indicated, and is then administered at the proper time, in effective doses, and with due precautions.

Imperial Granum.—A prominent Vermont physician writing to thank the Imperial Granum Company for copies of their famous Clinical Record, adds the following convincing words as to the merits of their product as a food for children: "I can show a baby that has been reared on—Imperial Granum—after trying numerous other foods until he was reduced to a mere skeleton—that is now as tough and strong a boy of fourteen months as can be found anywhere."

“WHICH OPERATION FOR SENILE CATARACT SHOULD THE BEGINNER SELECT?”*

By J. H. THOMPSON, M. D., of Kansas City, Mo.

THE art of extracting cataract is very much like the art of swimming—when one knows how to do it, it is very easy; when one does not know, it is very difficult. This knowledge, like all mechanical manipulations, requires practice. Only practice can make the master. Those who have had experience in the operation, have little difficulty to make a correct corneal incision, and do not care where it is, provided it is large enough. The delivery of the lens nucleus is the immediate object. How to do that cannot be taught—it must be learned. In fine, we must learn from experience; and, since that can only be acquired by operating on living human eyes, it is evident that the beginner is a poor ophthalmic surgeon. In this, I believe, you will agree with me, although the opposite is not necessarily true; for some men can never acquire a method of easy, smooth procedure.

The operation always requires considerable mechanical skill, for if a man cannot sew a button on his own coat, how can you expect him to take a mote out of his neighbor's eye? I believe that a preliminary iridectomy, made at least one month before the cataract is removed, is the safest operation for all surgeons, and certainly the best for the beginner. It may inconvenience the patient to remain under treatment too long a time, but the results are so satisfactory that a few weeks' delay should not influence the balance between an easy and safe procedure and another which may be quicker, but, in young hands, infinitely more dangerous. I, moreover, advance the opinion, without fear of contradiction, that for one-eye patients this operation should always be selected, even by the most experienced. The object is the restoration of the individual's sight; so, whatever way that can be most surely done, is evidently the best. Many operators tell us that the simple operation, extraction without an iridectomy, is very easy—more so than the modified Græfe. This may be true for those who operate several hundred times a year, but for the less fortunate it is otherwise. The fear of prolapse of the iris has always prejudiced me against the simple operation, although I must say, when successful, nothing more perfect can be devised. I cannot consider prolapse of the iris a simple accidental complication of the healing process. I must say that there is nothing in the whole domain of ophthalmic surgery I would dread more than to open an eye twelve to twenty-four hours after a cataract operation to cut off a prolapsed iris. My experience is, when it is necessary to interfere with an eye during the healing process, whatever may be the cause, the prognosis is bad.

It may be asked: why do I prefer the preliminary iridectomy to the iridectomy at the time of the extraction? My answer is, it is safer for this reason: all things being equal, the smaller the wound the quicker the healing, and the less the danger of infection. Fifty per cent. of those

* Read at the first session of the Western Society of Ophthalmology, Otology and Laryngology, Kansas City, Mo.

subjected to the combined operation suffer more or less iritis. Why? I am unable to say, but I think it is infection; for I believe it is not possible to prevent the entrance of infecting microbes into the anterior chamber after the cornea is incised over two-fifths of its circumference. It may be that the contact of the cortical remnants, or the aqueous fluid holding that material in solution, has an irritating effect on the freshly-cut iris tissue. Simply cutting the iris does not cause inflammation, for it is rather unusual to see iritis or find synechiæ after simple iridectomy.

There can be no doubt that it is easier to slide the nucleus through a coloboma which allows the iris to be pushed aside, than to force it through a normal pupil and over a cushion of iris tissue lying against the upper edge of the incision. All those who have had experience know that the corticalis can only be perfectly cleaned out when the iris is out of the way; and, since that material has some bearing on secondary cataract, it is best to remove as much of it as possible.

I have said it makes little difference where the incision is in the cornea, provided it is large enough; but the lay of the cut does make a great difference respecting the performance of an iridectomy. Expert operators can do that most difficult of all things—cut the cornea parallel to the scleral edge. With others, the tendency is to turn the edge of the knife outwards and make the apex of the flap too far in the transparent tissue. Again, young operators, in making the counter-puncture, are liable to push the point of the knife too far out in the sclera, which they see is dangerously near the base of the iris. Then they do what is necessary to be done under such circumstances—cut away from the dangerous zone. If they now attempt to make a correct iridectomy they must necessarily fail, for it would be impossible to drag the iris sufficiently far over the upper edge of the wound to cut it off near its base. If they do, hemorrhage will surely follow and complicate the operation, or the iris will be so severely injured that slow iridocyclitis will be the result. In my opinion, this is the reason why we so often see the pupil drawn to the upper periphery of the cornea.

Young oculists are as afraid of the vitreous, as beginning surgeons are of blood; and, until one has had much experience in ophthalmic surgery, he naturally and wisely avoids an extreme peripheral cut. He may have had the experience of the iris falling across the cutting edge of the knife when he has attempted to make a large wound. Such accidents are unavoidable, which, in the inexperienced, tend to mar the judgment and undermine the nerve; thus they often lead to disaster. If a section of the iris is made some time before, such complications may be avoided. The low flap will not give any inconvenience other than a little more difficulty to tilt the edge of the nucleus forward into the wound. This is an evil, it is true, but less to be feared than an extremely peripheral cut, plus a torn and bruised iris. A preliminary iridectomy offers another great advantage: We can thus more safely operate on immature cataracts. Beyond the suspicion that an iridectomy *per se* tends to hasten the ripening of a cataract, it has the advantage of removing from the field of operation a part of the iris which often gets caught upon the point of the knife in its passage across the anterior chamber. So long as the lens is not swollen and the aqueous chamber is deep, the incision is easy; but when the lens is large

and the iris is pushed forward towards the cornea, a large flap cannot be made without danger of injuring the iris. For that reason it is best to get the iris out of the way beforehand.

Again, we should select this operation for those cases of cataract wherein we have reason to believe that there is disease of the internal structures of the eye, or when the cataract is secondary. Preliminary iridectomy then offers the best possible chance to the patient. I am certain by doing this I have more than once succeeded, when, had I done the combined operation, I would have certainly failed.

From the above it is evident which operation I would recommend to beginners, and, if I suffered from cataract myself, which operation I would prefer to be done on my own eye. Make a preliminary iridectomy, and extract the cataract not sooner than one month afterwards, whether the cataract is ripe, overripe or immature. In all cases it is safe, and I am convinced by experience it will give the best results.

THE PUSTULO-CRUSTACEOUS SYPHILIDE.

By A. H. OHMANN-DUMESNIL, of Saint Louis.

WHEN pustulo-crustaceous lesions are noted in syphilis it is usually an indication of a comparatively late cutaneous manifestation of the disease. They also tend to show that the treatment pursued has not been sufficiently active in its nature, or that a total neglect of all treatment has occurred in a very short time after its inception. It may be added that the appearance of a pustulo-crustaceous or purely crustaceous syphilide is a more or less reliable indication that the general condition of a patient, as far as his tissues are concerned, is below par. This is in accord with the general observation that all suppurative processes which continue and do not heal spontaneously (so far as the skin is concerned) indicate the presence of a certain amount of constitutional debility which requires correction. This correction, in the case of syphilis, is a *sine qua non* to obtain a degree of success in the final disposition of the subject so affected. It must be understood that it is not alone sufficient to employ specific medication, but it is absolutely necessary to employ general roborant measures, such as iron, the bitters, and whatever else may be indicated by the necessities of a case. This course is to be pursued not only for the purpose of procuring a better general state, but also to bring about a condition of the tissues which will enable them, as a natural consequence, to offer a greater resistance to the deleterious effects of the syphilitic process. At the time that the pustulo-crustaceous syphilide has made its appearance, the luetic process has already firmly fixed its foothold upon the organism and is at that point when it threatens to bring about destructive changes, which are very apt to be of a very serious nature and not so easily amenable to treatment as its immediate precedents.

For these reasons it is not alone sufficient to employ specific medication of the best, but it will be found that roborant measures are also not

only necessary but indispensable. This is demanded not only to procure a better general state, but also to bring about such a condition of the tissues as will be much better and, as a natural result, offer a much greater resistance to the deleterious effects of the syphilitic process. The lack of success in the treatment of these forms of syphilis is often to be attributed solely to this very lack of attention to general treatment, and many a method has been descried, when, in reality, it was the fault of the physician, who depended too much upon "specific" medication, and lost sight of the quality of the material upon which he was working. In many cases the patient is actually injured by mercurial or iodic medication, where an adjuvant in the way of a good general tonic would have brought about the most happy results.

The different forms of the pustulo-crustaceous syphilides which are met with may be said to be almost infinite in number and variety. The lesions themselves are pustules primarily, but with such thin and frail walls that they soon burst open and pour out their contents, which rapidly dessicating form crusts, which are more or less adherent. A peculiarity which may be observed is that when several small pustules are situated close to one another, they are apt to coalesce and as a result a rather large crust is formed. In all cases it will be found that the crusts are always underlaid by a layer of pus and adhere chiefly by their edges; and, if several pustules have coalesced, the original dividing portion between them also becomes a point of adhesion for the crust. The lesions of the pustulo-crustaceous syphilide may occur in any locality, and it would require a volume to give pictures of the different localizations alone. The lesions also vary greatly in size. They may be small and aggregated; of a medium size and more or less disseminate; and, again, large and comparatively few in number.

This syphilide is more particularly to be observed in those who indulge in manual labor or who make much use of their muscles. Of course, this does not mean to apply that those who have never labored may not exhibit it. But, even in these latter cases, they are most often individuals who have deteriorated their general state of health by drinking, debauchery, exposure and lack of good food, not to mention exposure and other unhygienic surroundings. Brain workers, such as authors, business men, students, and professional men in general, are by no means as prone to exhibit these lesions as laborers. This is a matter of common observation, and is a valuable guide when the treatment of a case at its inception is undertaken. For, whilst the individual who uses his muscles must be given those means which shall increase his muscular and analogous tissues, brain workers must have their entire nervous system placed in the best possible condition. It must not be forgotten, however, that those who are not cleanly in the care of their persons, or who, as occurs in many cases, are positively filthy, are very apt to exhibit this form of syphilide than those who are cleanly. On the other hand, it is sometimes encountered in the most cleanly.

The pustulo-crustaceous syphilide manifests itself in a number of different forms, which may be reduced to three general types. In one form there is quite a marked dissemination of the lesions at the beginning of the eruption. The pustules are pin-head in size and closely aggregated. In a

very short time they burst, but they do not all do so simultaneously. On the contrary, a certain limited area will present its surface as the site of the



FIG. 1. Pustulo-Crustaceous Syphilide (Small Disseminate Form).

burst papules, and these pour out their contents, consisting of pus, some blood, and serum. This rather quickly dries, and yet there remains a certain quantity of pus which forms a thin layer under the crust which has

formed. The crust not permitting the escape of pus from the original lesions, the process becomes more disseminated until the entire lesion resembles a superficial ulcer when the crust is removed. This form might



FIG. 2. Pustulo-Crustaceous Syphilide (Large Discrete Form).

very aptly be termed the disseminate superficial pustulo-crustaceous syphilide. A glance at Figure 1 will give some idea of the appearance of this eruption. It must not be supposed, as the picture would seem to indi-

cate to some, that this form of syphilide involves the entire body at once. A whole limb, or a large patch of the trunk, or the face and scalp may be involved, or we may even have both arms and a large patch in the back or breast occurring at one time. But, in such an instance, the eruption is



FIG. 3. Pustulo-Crustaceous Syphilide ("Epaulette" Form).

looked upon as being rather disseminated over the body. There may be some little pain present, more especially on pressure; but, as a rule, no subjective pains referable to the eruption are ever complained of by the patient.

Another variety of this eruption is one in which there are comparatively few large discrete lesions, distributed in a rather symmetrical manner. The extremities, the trunk, the face or head may be the sites selected by the process, and it is usually in cases which have been treated that this form of the eruption is most frequently seen. A good example is given in Figure 2; and it will be observed that the lesions are somewhat irregular in outline, showing that there was originally a number of pustules which took on a confluent action, and the resultant crust adopted a form which embraced the location of each one of the pustules which preceded its formation. In the case which is figured the paucity in number of the crusts is well shown as well as the symmetry of distribution. The location shown is not an unusual one for this form of the pustulo-crustaceous syphilide, more especially in those who must do heavy work in the way of lifting articles which have a considerable weight. Another reason for the selection of this particular site of the process is the fact that the inner and upper portions of the thighs are prone to be subjected to friction and, furthermore, present a very good surface for dust and dirt to attach itself through means of the perspiration, which is always plentiful in those localities. These forms of irritation certainly conduce not only to the formation of pustules, but also exercise a certain influence in bursting them, which latter leads to the rapid formation of crusts.

Among the peculiar localizations of the pustulo-crustaceous syphilide occasionally observed is that which I have denominated the "epaulette" form. A good representation of this rather unusual form is given in Figure 3. As can be readily seen from the figure, there is present upon either shoulder a crust in the form of a strip two and one-half to three inches wide. These strips consist of a more or less firmly adherent crust, which is rather thick. Its edges, however, are not very firmly adherent to the skin which underlies it. If the crust be lifted, however, it will be found that a rather thin pus is present, and this is more plentiful in a patch-like form, there being a number of disseminated patches somewhat deeper than the rest of the surface, pointing very distinctly to the fact of the previous existence of a number of pustules which were aggregated in variously sized patches. In the case figured a few distinct pustules may be observed upon the left arm, and this points to the fact, in a most unmistakable manner, that the more obvious lesions were at first of a purely pustular character. The crusts, which are inclined to be of a reddish-brown or blackish-brown color, are pretty sharply defined against the unaffected integument, and this attests, in great part, the limitation of the process which is inherent in itself. This form of the pustulo-crustaceous syphilide has not been noted by authors with that exactness which its comparative frequency would seem to demand. I have never seen it show itself in any but laboring men, or in those who indulge in manual labor and who perspire freely and profusely. I have, furthermore, observed that it only occurs in a small percentage of these. The patients themselves seem to have observed the probable cause; and it is not only a rational explanation, but the only one which can be made. The location of the crusts, for each one is practically one crust, is where the suspenders exercise friction upon the shoulders (and, it may be added, the patient depicted, contrary to the usual custom of laborers, wore suspenders). It is for this reason that the left side presents

a much more extensive lesion anteriorly than the right, as is shown in Figure 3. We must remember, however, that, in working, the right shoulder is thrown back much more than the left, and, as a natural consequence of this movement, the friction is not spread over such a large surface as on the right side, anteriorly. On the other hand, the extent of surface involved on the back is directly the reverse, although the comparative difference is not as well marked. At all events, the constant friction of the suspender has quite a tendency to irritate an already predisposed skin, and the first lesions to appear are papules. These are rapidly transformed into pustules; the pressure breaks these and crusts are formed, as already explained above. The small amount or total absence of pain easily leads to the formation of these secondary lesions, and it is not until the process has become both extended and extensive that relief is sought.

As in other forms of extensive syphilitic involvements, the general condition should receive attention, and it is especially in workmen that the good effects of general mild stimulating and roborant remedies will be observed. An eligible preparation of kola will not only act as a most valuable stimulant, but it will aid the patient in a most satisfactory manner to work and, at the same time, derive the entire benefit of the specific remedies which are administered. To be enabled to bear the effects of work without experiencing over-fatigue, and this is what is attained by the use of kola, renders the tissues much more receptive, and much better results may be expected from the use of specific remedies. After all, this is the great objective point, and it is in consideration of these facts that a good preparation of kola makes its full value known to the patient and physician alike.

So far as the specific treatment of the pustulo-crustaceous syphilide is concerned, it will be found best to begin with a mercurial, and there is, perhaps, no better form in which to administer it than mercauro. To begin with, eight or ten drops should be given in water after each meal, and this dose gradually increased until twenty or twenty-five drops are taken, unless such untoward symptoms as dizziness, nausea, etc., manifest themselves, when it is to be discontinued, and, after a time, be resumed. In many cases this treatment alone suffices; but in others it is necessary to resort to the mixed treatment in order to procure final and lasting results. The following will be found both efficient and thorough:

℞ Hydrarg. bichloride.....	gr. iij.
Kali iodidi	ʒ v.
Syr. sarsaparillæ	ʒ ijss.
Aquæ destillat	ʒ jss.

M. Sig. A teaspoonful in milk after each meal.

Other forms of mixed treatment may be employed, but the above will be found quite satisfactory.

So far as local treatment is concerned, it should by no means be neglected. The first thing to do is to remove the crusts by means of some bland and unirritating agent, such as sweet oil or oil of sweet almonds. A comparatively clean surface will then be offered for treatment and then it should be washed with a 1 to 500 solution of corrosive sublimate. Following this an ointment or a powder should be applied, and finally a good dressing. As a powder the campho-phénique powder acts remarkably

well, as it is not only antiseptic but slightly stimulating and analgesic as well. If an ointment be prepared, one like any of the following may be used:

℞	Hydrarg. oleat, 10 per cent.....	ʒ ss.
	Ung. hydrargyri	ʒ jss.
M.		
℞	Ung. hydrarg. ammoniati.....	ʒ iij.
	Ung. aquæ rosæ	ʒ j.
M.		

A rapid return to the normal will follow this treatment, but it should not be forgotten to follow it with a long course of systemic medication in order to prevent any serious post-syphilitic phenomena.

THE RELATION OF THE SCIENCE OF MEDICINE TO PUBLIC SCHOOL EDUCATION.*

By JOHN PUNTON, M. D., of Kansas City, Mo.

THE subject of education, in its highest and widest sphere, is daily becoming of more practical interest and importance. In the evolution of civilization there never was a time when its value as a reforming agent was at a greater premium than the present. Like all other powerful reforming agents, the scope of education has been gradually enlarged by keeping step with the march of progress, until to-day its elevating and preserving influence permeates all the ramifications of our business and social life.

Much, therefore, depends upon our interpretation of the true function of education, as well as its practical relation to the demand of our present life and modes of living.

If education in its broadest significance embraces, as we are taught to believe by the leading educators of the world, all the elements which enter into and form part of our social fabric, then certainly its chief object is to train individuals to become intelligent, moral and self-supporting citizens, at the same time eradicate or at least modify or correct all undesirable tendencies in both mind and body which oppose such a favorable state.

This, therefore, concerns the development of the whole man—his mental, moral and physical powers and capacities—besides the recognition and correction of any abnormal or pathological tendencies which may seem to even lean toward his social degeneracy.

In view of such facts it is clear to all that the basic element of all true education is closely allied to the science of medicine; indeed, education is rapidly becoming a medical question of the highest importance, and at once becomes the duty of the physician to not only demonstrate but promulgate its special significance and value to the individual pupil as well as parents and guardians.

The vital relation of medical science to the proper protection and pres-

* Read before the Tri-State Medical Society of Iowa, Illinois and Missouri, at St. Louis, April 7, 1897.

ervation of the health of the race, on the one hand, and the prevailing vices and social evils, on the other, together with their special relation to public school education, is at once self-evident to every unbiased mind.

That the truly medical aspect of public education has until within quite a comparatively recent period been entirely ignored or overlooked by our prominent educators is now generally admitted.

The recognition and introduction of medical science in educational methods therefore marks a new era in the progress of civilization.

That serious defects in the recognized routine methods of public school education and training of pupils, not only formerly, but still exist, is attested by the general public, as well as the officers and teachers of the schools themselves.

One recent writer in the *Outlook* (see March 15, 1895) commenting on this, says: "That there are grave defects in our present school methods is denied by no one competent to express an opinion on the subject. One of the crying faults is the attempt to do too much in the schools. The course of study is overcrowded, and the result is that the scholar learns nothing thoroughly. The advocates of this method assert that it is best for a child to learn a little about a good many subjects, even if it is only the barest smattering. This is radically a wrong principle."

Again, in a report just issued by the president of the Board of Education of Brooklyn, New York, among other things he said: "The curriculum is overloaded with subjects, ornamental and otherwise. Thus the children are hurried along from one subject to another with results that are disastrous to them and disheartening to their teacher."

In the *Atlantic Monthly* for last July ('96) the editor invited a number of principals of public schools to frankly relate their careers as teachers and confess their grievances. These confessions of public school teachers, selected at random from all parts of the country, all go to show that there are grave defects in our present educational methods, which they claim are largely accounted for by the extent to which the local politicians in many parts of the country keep their hold on the appointments of teachers, as well as the pernicious influence exerted by the publishers of text-books, in the selection and retention of incompetent school officers and teachers.

"All of the writers confess that their own training was inadequate, and that the teachers who now enter the profession have also been inadequately trained."

M. J. Savage, writing in the *North American Review*, sums up an elaborate article on the defects of the public school system, as follows:

"I propose now to reinforce the opinions so far expressed, by a few definite specifications and statistics.

"The defects of our present common school system may be summed up under two heads: 1st. It attempts to do too much, and so goes beyond its legitimate province. 2d. While trying to do what properly lies beyond its own borders, it fails to produce satisfactory fruits within its own field. In trying to do too much, the system fails in doing what it might and at least ought to attempt on behalf of the great and overwhelming majority.

"It does not give them the best instruction and training for the real life which they must lead. As already shown, their success in life depends on a practical knowledge of their own bodies, and on moral training, much

more largely than on most things about which they are actually taught. And in these two directions almost nothing is being done."

In one of the recent editorials of a New York religious weekly (*Christian Advocate*, Methodist, November 7, '96) the editor justly criticizes the action taken by the New York Teachers Association at their meeting held at Syracuse, New York, when they passed a series of resolutions, condemning the passage of a law requiring the compulsory teaching of physiology in the public schools. Here is what they say: "Whereas, the legislature has placed upon the statute book a new law concerning the teaching of physiology, a law contrary to all principles of correct teaching, opposed to all school laws and customs, interfering as it does with the courses of study, and with the details of school work; therefore, resolved, that the New York State teachers denounce that law as an insult to the State and a menace to the principles of free school teaching," etc.

No wonder the editor was led to remark: "Considering their positions as instructors of youth in the pay of the public, and the far-reaching character of their influence through their example and spirit, they might have written in better style such resolutions as they saw fit to pass. The first resolution is grossly improper and introduces a personal element which weakens their position and will create an antagonism on the part of the legislature to themselves."

I have purposely seen fit to cite these numerous opinions in order to prove that it is not my purpose to make any imaginary criticisms or introduce any personal charges, or even conjure for this occasion some undeserved remarks, but simply wish to show that not only the public recognize that serious defects exist in the present public school system, but also members of their own profession, which no doubt often handicap their own best efforts.

The object of this paper, therefore, is not intended to antagonize but rather co-operate with the school officers in an endeavor to overcome many existing evils. By such a process of reasoning together it is more than possible much good can be accomplished by emphasizing the importance of the relation of the science of medicine to public school education on the one hand, and the purely pedagogic relation on the other. From the foregoing it is clear to all that reforms are needed, and while many plans have been devised it seems to me none have met the indications like the practical philosophical principles embodied in the new medical psychology, the basis of which recognizes the education of pupils from a purely physiological or medical standpoint.

The great question to-day with the leading educators of the world, then, is not so much what a pupil can be forced to accomplish in a given length of time, as what are his, or her, capacities to safely study and acquire that kind of knowledge which is most essential for their own physical, mental and moral preservation, and that of their fellow-men; and this, I take it, embodies the chief elements of good citizenship, which is, or should be, the prime object of all true education.

That this great question can be solved more satisfactorily by the methods embraced in medical psychology, I think there can be no doubt. It is, therefore, fitting for us to briefly review some of its more practical aspects which so far have been clearly demonstrated in the public school. Without

any desire to burden you with unnecessary detail, it may be said that this great movement had its origin in Europe, and having run the gauntlet of bitter prejudice and ridicule for many years, during which time it gradually demonstrated its scientific accuracy and usefulness, was finally in its more matured state transported to America, no longer than fifteen years ago.

To G. Stanley Hall, of the Johns Hopkins University, more than to perhaps any other man are we indebted for not only its introduction, but also very largely its present state of development and efficiency.

With an extremely modest beginning it has grown under his sagacious leadership and those of his pupils, until to-day no first-class educational institution is complete in all its details without its psychological laboratory.

From time immemorial logic-ethics and psychology has been recognized as the golden link which formed the culmination of a finished education, but it has taken centuries to unravel the true significance and value of each and finally recognize beyond a doubt that all rational and effective education is based on psychology—not the vague verbose psychology of twenty years ago, but the accurate, up-to-date, medical psychology of to-day.

One of the chief departments which belong to this new psychology is the science which treats of the physical and intellectual characteristics of the different races of mankind, and technically known as anthropology.

Its extensive range admits of subdivision, the chief of which perhaps is anthropometry, or the science which relates to the measurements of the human body.

Having become interested in its practical utility as a means of determining certain physical standards for certain ages in the period of school life and work, and more especially those ranging from 13 to 21, as well as their relation to the adjustment of proper school tasks, based on the physiological principle which takes cognizance of the pupil's individual physical strength and capacity, I applied to the Board of Education for permission to make certain anthropometrical investigations in the Kansas City High School, which was granted. In order to insure accuracy I called to my aid Dr. F. L. Riely, physical director of the Y. M. C. A. gymnasium, together with several medical students, and I now take pleasure in presenting a partial report of our findings.

It is now about two years since we commenced our work, and the progress while being somewhat slow has been very thorough and complete in all its details.

In a paper which I read before our local society, about four years ago, I stated it was my firm conviction that the age of a child, when taken as a criterion for its mental strength and capacity, was a very erroneous one and full of deception, and that it was far more logical and scientific to allow the height and body-weight of a pupil to govern this important question. This statement, which at the time was received somewhat in the light of a joke and regarded as a pretty theory, but very impractical, has become eminently true and intensely practical when actually applied in the school-room.

Moreover, in my original paper I also called attention to the fact that it was my firm conviction that the local city authorities are too prone to ignore medical aid in their sanitary and educational legislation. No class of persons are better prepared to offer more useful advice in such matters

than the well-trained, educated, scientific physician—more especially is this true of education; and I then stated that it was my belief that a wisely selected medical board should be appointed in every city and town, whose duties should be to visit the public schools and inspect the pupils and determine their physical condition as well as their capacity for study; and I also gave several good reasons for entertaining such a view. This statement was also received with more or less contempt and ridicule, but, strange as it may appear, in less than twenty months from that time this very principle was put in practical operation, in no less a place than the so-called center of American culture, viz.: Boston, and to-day it affords me pleasure to present an extract from the first report, just issued, of the results of the medical inspection of the Boston public schools.

MEDICAL INSPECTION OF BOSTON SCHOOLS.

A report recently issued by the state department shows that the inspection of the Boston schools by physicians has been followed by excellent results. The schools have been visited daily, and all the children who have complained of illness or appeared to the teachers to be ill have been examined by the visiting physician, who, in all cases, advises the teacher what to do with the pupil. The report says:

“This work has now been in progress for fourteen months, and it has demonstrated that there are many cases of contagious diseases in the schools, and large numbers of school children whose illness and whose disposition by the teacher requires the decision of a competent physician.

“For the fourteen months ending December 31, 1895, 16,790 pupils were examined, 10,737 of whom were found to be ill, 6053 were found not to be ill, and 2041 of these were too ill to remain in the school for the day. There were 77 cases of diphtheria, 28 of scarlet fever, 116 of measles, 28 of chicken-pox, 69 of pediculosis, 47 of scabies, 47 of mumps, 33 of whooping cough, and 8 of congenital syphilis in children sitting in their seats and spreading these diseases to other children. The remaining 10,372 sick children were suffering from a large variety of diseases.

“These results justify the work so far, and show the need of extending it. A corps of medical inspectors sufficiently large to permit an intelligent physician to spend at least a few minutes daily in every school-room would detect many cases needing attention, yet not apparent to the average teacher, and of bad sanitary conditions that go unheeded from month to month. Much of the sickness and enfeebled state of school children is due to the conditions of their school-rooms. Children sit with cold or damp feet because the heating apparatus afford no chance to warm or dry them, and they suffer from insufficient light and ventilation, when both might easily be provided.

“New York City has also lately followed in the wake of Boston in appointing medical inspectors of public, parochial and private schools for the purpose of reducing the number of cases of contagious diseases.

“Each child is to be examined daily, and when absent because of sickness, the nature of the sickness will be investigated. The press reports say that many prominent physicians have applied for appointment on the staff. The office of inspector is worth \$300 a year. Among the applicants for this position is a professor in one of the medical colleges. The appli-

cants for appointment on the staff are of both sexes, but President Wilson will give preference to the summer corps of physicians. Provision is made for a staff of 150 at \$30 a month. The chief inspector will receive \$2,500 a year. Competitive examinations will determine who are to have the places. President Wilson recommends that the summer corps be not required to pass examination. He will also recommend that the competitions be by districts, so that the physicians appointed be residents of the districts in which they are to serve."—*Kansas Med. Jour.*, Jan. 30, 1897.

You will observe that these reports largely pertain to the prevention of contagious diseases, and while I believe this to be a step in the right direction, and deserves the hearty co-operation of the entire medical world, yet I am certain that there are other prophylactic measures equally as necessary to enforce both in and out of the school-room which the science of medicine plainly teaches, before we can successfully overcome the production and spread of disease among the pupils of our public schools.

In my judgment a very important agent, and one which so far has been very largely ignored in the prevention of diseases among school children, is the enforcement of the principles embodied in the science of anthropometry. In almost every large city in the world anthropometrical investigations have now been made in the public schools, and the unanimous verdict has been reached that the mental output of the pupils is directly related to their heights, weights and physical measurements, and that there is a physical basis for precocity on the one hand and mental dullness on the other.

What is necessary to be done, then, as I stated in my former paper, is to fix certain definite standards of weight and measurements for every age and height, and any pupil found to be below or above this fixed standard should be treated accordingly.

In this way it would be possible to greatly aid the proper physical and mental development of the pupil by assigning to each appropriate studies, besides overcome to some extent at least much of the disease incident to school life and work.

The practical utility of such a method has already been ably demonstrated in a series of charts by Dr. Dudley A. Sargent, of Harvard University, and Dr. Seaver, of Yale, both of whom have been engaged in this work for some time, and by which it is now possible for us to compare the health and general physical condition of the boys and girls of Boston with those of our own and other cities.

It was our desire to make investigations along similar lines in Kansas City, and for this purpose we selected at random from the general assembly hall of the High School 200 boys and a similar number of girls, whose ages ranged from 13 to 21, and subjected them to a similar examination as pursued in other large schools.

The result of our investigations prove conclusively that out of 200 boys examined 34 per cent. were found to possess a nervous temperament, as demonstrated by either a history of direct inheritance or the character of the pulse; and 35 per cent. of these were found to be subject to physical defects.

When the measurements of these nervous children are compared with Dr. Sargent's chart of the Boston boys at the same age, we find that the

weight of our boys was $6\frac{3}{10}$ pounds less and the height $\frac{9}{10}$ of an inch less than the Boston boys, while the heart-rate was also 6 beats per minute faster.

Not only were these nervous children found to be deficient in weights and measurements, but the *general average of all the boys examined* was found to be in nearly every instance deficient in weight, height and other vital measurements.

For instance, the average weight of the Kansas City High School boy, at the age of 16, is 126 pounds against $132\frac{3}{10}$ pounds of the Boston boy, while the average height of the Kansas City boy is 5 feet $6\frac{7}{10}$ inches as against 5 feet $7\frac{1}{2}$ inches of the Boston boy, a clear loss of $\frac{8}{10}$ of an inch. Again, the girth of the neck, which is considered one of the most vital measurements of the body, was also deficient.

Besides this the breadth of the shoulders was found to be deficient to the extent of $\frac{8}{10}$ of an inch.

The expansion of the chest, which is also a valuable guide to the lung capacity, was found to be $\frac{1}{2}$ an inch smaller than the Boston boys of the same age.

In nervous force, which was measured by a dynamometer, we found it to be equal with the eastern boys of the same age, which would suggest at least, in view of all the other deficiencies, that our own boys were using more nervous force at the expense of their physical strength than were their Boston cousins.

The average heart-beat of nine-tenths of the boys examined in our High School was 84, which is entirely too rapid for health and is in itself an indication of physical weakness.

In comparing the results of Mr. Greenwood's (superintendent Kansas City schools) measurements, taken in 1886 and again in 1890, with those of Dr. Sargent's, of Harvard, we find that the comparative weight and height, at the same ages, of the Kansas City and Boston pupils were as follows:

KANSAS CITY.			BOSTON.		
AGE.	WEIGHT.	HEIGHT.	WEIGHT.	HEIGHT.	
14	$92\frac{2}{10}$ pounds	4 feet $10\frac{1}{2}$ inches.....	$99\frac{1}{2}$ pounds.....	5 feet 2 inches.	
15	$107\frac{3}{10}$ pounds.....	5 feet $2\frac{8}{10}$ inches.....	112 pounds.....	5 feet 5 inches.	
16.....	119 pounds.....	5 feet $3\frac{9}{10}$ inches	132 pounds.....	5 feet $7\frac{1}{2}$ inches.	
17	$126\frac{6}{10}$ pounds	5 feet $4\frac{8}{10}$ inches.....	$134\frac{1}{2}$ pounds.....	5 feet $7\frac{8}{10}$ inches.	
18	$136\frac{8}{10}$ pounds.....	5 feet $6\frac{6}{10}$ inches.....	135 pounds.....	5 feet $7\frac{8}{10}$ inches.	

This proves that, with but one exception, the weight and measurements taken by Mr. Greenwood, as well as our own, were much less than those found in the chart of Dr. Sargent for the same ages. What causes the school children of Kansas City to be so very inferior, from a physical standpoint, than the Boston children, is a problem not easy to solve.

It has been suggested, however, that it might be due to climate, and in support of this it is asserted that during the war southern soldiers were very much smaller in stature and general physique than were the northern ones. It is also claimed that even to-day the school children of the south are much smaller in every way than are our own.

Another reason assigned for the apparent grave physical defects is that the percentage of foreign born children is greater in our schools than

those of the east; but this view cannot be sustained by facts, for we found it to be less than twenty per cent. Still another view is that our eastern friends are much slower in their movements and take life more easy than we do, hence their development, as well as their children, is more in accord with physiological law. But the most important view to us is that the children of Boston are compelled to take systematic physical culture as part of their school routine, and that the good effects of physical culture is more generally recognized in the east than in the west. Let this be as it may, there are several other good reasons which might at least suggest the cause. For instance, if the statement made by our recent visitors from New York be true, viz.: That in their opinion the Kansas City High School was unexcelled in this country for its high standard of proficiency, then it would seem to suggest that possibly its high standard of excellence was gained at the physical expense of its pupils, just on the same principle that a minister of the gospel gets the credit of building a church, when in reality it is built at the expense of its members, due possibly to the minister's ability to increase the spiritual zeal and zest of the membership.

Many a school undoubtedly gets its reputation of excellence at the expense of its various teachers' ability to extract the greatest amount of brain tension from its pupils in a limited length of time; hence it is that (I learn from good authority) the teachers of the Kansas City High School place a premium on their examinations by grading them into three classes, viz.: the highest, middle, and lowest grade; consequently the pupils naturally strive their utmost to gain the first place rather than have their apparent ignorance exposed to the world.

The shock to the nervous system from failure to reach the coveted prize cannot be overestimated, and no one has a better opportunity to know the evil results of such a practice than the family physician.

From the foregoing it is evident to all unbiased minds that there never was a time when the brakes needed applying more than the present, and it becomes the duty of the medical profession to sound the alarm and insist on their application.

But while many faults may be found with our present school system of education, it is not by any means all due to the officers and teachers of the schools themselves, but, in my opinion, the chief difficulty can be directly traced to the parents and guardians, as well as the home life of the pupil.

Many a child is compelled by its parents to sacrifice its constitution for what is deemed by them its educational necessities. In their anxiety to have their child excel and appear smart, the parents are willing to witness its slow but certain death from sheer exhaustion, due to overpressure, by thus making its physical health subservient to the intellect. The parents are even known to employ private teachers to coach their children after the regular school hours, besides depriving them of many a legal holiday. If their child happens to be "put back," from any cause, by the teacher, they then make a move to have him or her displaced, on the ground of incompetency. It is here where I think the medical profession can be of valuable service to not only the teacher but the child, by being a just mediator and armed with all the authority to decide such questions instead of appealing to either parent or teacher.

What our present system needs to fear then more, perhaps, than any-

thing else, are the home influences of the children and their overzealous parents' lack of knowledge of the evil effects of excessive mental and physical strains.

The relation of the science of medicine to public school education, then, is rapidly becoming of more practical interest and importance, and the duty of the physician is not fulfilled or complete when he fails to recognize this particular part of his function; for in the light of facts, who can truthfully argue that it is not the business of the physician to at least advise, if not dictate, in matters pertaining to the general education of the rising generations.

That the education of children is rapidly becoming a question which must largely be referred to scientific medical methods is plain to every thoughtful person, and the longer the medical aspect of education is ignored by our educators the greater the evil will become. What is needed to be done, then, is for the school teacher and physician to harmonize the discordant elements of home life and school life, thus placing the pupil in the best possible condition for the safe acquirement of knowledge.

Not until this is done can we ever hope to overcome the many evils that are clearly traceable to school life and work.

In view of all the facts presented by our investigations, therefore, we believe the following deductions can safely be made:

1st. That our High School admits pupils at the age of 13, which we think is altogether too early an age to take on the required studies.

2d. That the mental capacity of a pupil is largely governed by the height, weight and measurements of the body.

3d. That the pupils of our High School are much less in height, weight and measurements than the Boston pupils of the same age, and that the former are considered by good authority to be the normal standard.

4th. That definite standards of weight, height and other measurements for each age should be fixed to govern a pupil's capacity to study.

5th. That, mentally speaking, the pupils are now being overburdened in proportion to their age, height and physical capacity.

6th. That the parents of pupils are possibly as much or even more to blame for this than are the school officers and teachers, by their overzealous anxiety for their children to excel and appear smart.

7th. That it is our belief that the knowledge gained by the prevailing cramming process is not as lasting or as fruitful in results as that which occurs from more conservative methods.

8th. That many of the defects found to exist in pupils can largely be overcome by more careful attention to the laws of physiology and hygiene.

9th. That there is a growing demand for medical inspection of public schools, in order to protect and preserve the health and lives of the pupils as well as society at large.

10th. That the larger the percentage of nervous children in a school, the greater the tendency to lessen the general average of the whole.

11th. That nervous children possess in proportion more physical defects than all other pupils.

12th. That the nearer the pupil approaches the normal fixed standard in height, weight and other measurements, the greater his mental strength and capacity for study.

13th. That overmental stimulation dwarfs the mental and physical power and capacity by weakening the heart action, as evidenced by an accelerated pulse-rate.

14th. That the health of pupils, as well as their education, should be subject to the laws of physiology. (RILEY.)

A MEMOIR ON THE ODORIFEROUS SENSE.

By J. MOUNT BLEYER, M. D., F. R. A. M. S., of New York City.

[CONTINUED FROM APRIL ISSUE.]

The nerves ramify so as to form flattened tufts, the filaments of which, spreading out laterally and communicating freely with similar offsets on each side, form a close plexus with elongated and narrow meshes.

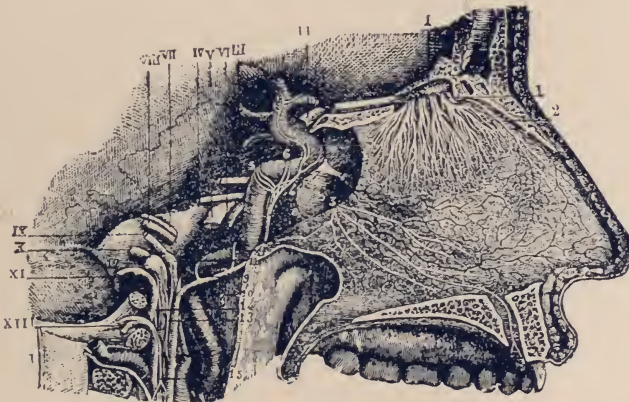


FIG. VI. Nerves of the Septum Nasi Seen From the Right Side. (From Sappey, after Hirschfeld & Leveille.)

I. The olfactory bulb; 1, the olfactory nerves passing through the foramina of the cribriform plate, and descending to be distributed on the septum; 2, the internal or septal twig of the nasal branch of the ophthalmic nerve; 3, naso-palatine nerves.

The structure of the olfactory nerve-fibers differs from the ordinary dark-bordered fibers of the cerebral and spinal nerves. They possess no medullary sheath, but are axis-cylinders provided with a distinct nucleated sheath much more distinct than that of the fibers of Remak and with nuclei at less frequent intervals.

The greater part of the mucous membrane of the nasal channels is provided also with nerves of common sensibility, derived from branches of the fifth pair.

According to recent discovery, each of these fibers most probably, approaching one of these cellules of the outer coating, fixes itself to its rear extremity. If this observation be correct, those vibrating cellules have the significance of end organs of the nerves of smell; that is, they are to be regarded as the apparatus upon which the odorous substance acts,

producing a physical or chemical process, which excites the nervous fibers springing from the cellule, develops a nervous current and sends it to the brain. This view is now exceedingly well supported. The fact that an odorous substance causes a sensation of smell on the slightest contact with the mucous membrane of the nose becomes explained when it is assumed



FIG. VII. Nerves of the Outer Wall of the Nasal Fossæ. (From Sappey, after Hirschfeld & Leveille.)

1. Net-work of the branches of the olfactory nerve, descending upon the region of the superior and middle turbinated bones; 2, external twig of the nasal nerve; 3, sphenopalatine ganglion; 4, ramification of the large palatine nerve; 5, small, and 6, external turbinated bones; 7, branch to the region of the inferior turbinated bone; 8, branch to the region of the superior and middle turbinated bones; 9, nasopalatine branch to the septum, cut short.

that the substance acts first on the cellules bordering on the nasal cavity; it remains an enigma if it is to be assumed that the odoriferous substance has to soak through the cellules into the tissue of the membrane under it, in order to reach the nerve of smell which it is going to affect. But how an odorous substance, whatever it be, acts upon the cellules or vesicles,



FIG. VIII. Nerve-Fibers From the Olfactory Mucous Membrane. (Max. Schultze.) Magnified between 400 and 500 diameters.

From a branch of the olfactory nerve of the sheep; at *a, a*, two dark-bordered or medullated fibers, from the fifth pair, associated with the pale olfactory fibers.

and upon their contents; what takes place in the vesicles; how by this process the nervous fibers become affected; how the influences of the various odorous substances differ from each other; all these are problems towards the solution of which no path offers as yet to lead us, or is likely soon to be discovered.

We cannot hope to see the torchlight of scientific inquiry illuminating the mysterious processes which we have just hinted at before accomplishing two essential tasks: First, the understanding of the external affection of the nerve of smell—that is, of the qualities which render a substance odorous, and of the forces by which it indirectly acts upon the nerves; and, secondly, a clear conception of the conducting process in the nerve itself of the so-called nervous current. The unavoidable necessity of making these preliminary scientific steps is as obvious as the sad truth that physiology is yet helplessly ignorant of how to make them. Of our ignorance of the nature of the affections of the nerves, much has been written; the complete obscurity of the exciting agent will be alluded to in this memoir. If we take, for instance, a simple smellable substance, like oil of roses, or a simple elementary one, as chlorine, while we know precisely all its physical and chemical qualities, we are unable to state which of these qualities makes it odorous; why another gas, as, for instance, oxygen or hydrogen, is inodorous—that is, does not act in the required way upon the nerve of smell, or, rather, on the substance of its end organs. Our scientific ancestors, it is true, knew well how to get over this difficulty; they invented a fine name for the unknown principle of odorous substances, and with that they were perfectly satisfied. They assumed a special *spiritus vector* inherent in odorous substances, without, however, being able to connect any clear idea with that name. Here I must again decidedly come forth and combat an erroneous conception, though by so doing may risk being accused of useless repetition, having already in the general introduction commenced the warfare against the same deep-rooted error. Every one, even if uninitiated in science, when asked about the qualities which render a substance smellable, will designate the odor itself as the quality inquired after, believing that a certain odoriferous essence from without has come to our consciousness as a detached part of the essence of that substance which, by way of experience, has been found out to be the nearest cause of our sensation. Every one will attribute the quality of the sensation to the external object which is the cause of the sensation as properly belonging to that object; this is the fundamental error. I speak of the same which makes us attribute the blue or green color to the external light, or to the light spreading objects, to the “blue sky” or the “green meadow,” and the sound to the vibrating cord. To repeat, the quality of the sensation of smell of which we become conscious has nothing in common with any quality of a so-called odorous essence; just as little as light developed by two carbon poles on the passage of a galvanic current has anything in common with the properties of the two metals which have produced the galvanic current, and have become the indirect causes of the carbon light; as essence of violets is the direct cause of the odor of violets. I need not repeat how we are brought to attribute the qualities of all our sensations to the external objects which the same habitually imagines to be the cause of sensation; it has been seen how this way of rendering our sensations objective is, on the one hand, the necessary result of the education of our senses in the service of the soul, and on the other, the principal condition of the measureless benefits they bestow on it. It is, therefore, an error the origin of which is unavoidable, and its existence indispensable, which science must recognize as error, but which it cannot prohibit or destroy.

The physiologist himself who teaches that color is not the quality of light, regards, like all, the sky as blue, and the trees as green, and as obstinately as all places the sound in the cord, and the scent in the violet; he fares like one seized by giddiness, who sees tables and chairs whirling around him, and though convinced of their standing firmly at their place is unable to resist the delusion. We all firmly believe in the theory of the astronomers, that the sun is at rest and the earth in motion; and yet our eyes again and again give the lie to the great dogma enunciated by Galileo. From sunrise to sunset they whisper to our soul of the sun what he told of the earth—"and yet it moves;" and our credulous spirit, which piously follows the demonstrations of its first teachers, the senses, is easily seduced, and in spite of its better knowledge accomodates all its conceptions to the insinuations of the eyes.

If it cannot be explained what makes a substance smellable, what the sensation of smell is, nor what series of physiological processes intervenes between the action of an odorous substance on the mucous membrane of the nose and the rise of the sensation, at least we are able to elucidate some of the interesting conditions within which a sensation of smell takes place.

This fact is known to everybody: that odors are inhaled by the nose; that is, that a sensation of smell arises when odorous substances, blended with the atmospheric air, enter the nasal cavity in consequence of an inhalation. The entire mechanism of respiration is here brought into action. The two orifices, consisting of the oral and nasal cavities, are the principal ones which play the role in physiological action of conducting smellable bodies to the odoriferous organ. Both organs—oral and nasal cavities—are under the control of the will, so that the air is made to rush into the expanded chest either by both or one of them. At the time of regular and quiet breathing the oral cavity is generally closed, so that the air enters the chest only through the nose, and leaves it when contracted through the same; in this way light currents of atmospheric air continually pass by the mucous membrane of the nose, and each conveys to it what ever of odorous substance it has absorbed. Daily experience teaches that when regular quiet breathing through the nose takes place the sensations of smell are comparatively faint; that their intensity increases considerably when the air is inhaled through the nose by strong and rapid blasts; that thus are repeatedly executed short but strong inhalations through the nose by intentional smelling or snuffing. Finally, it is a well-known fact that even in an atmosphere saturated with most intensely odorous substance we do not smell anything when inhaling the air exclusively through the oral cavity; though without closing our nostrils with our fingers, so that the odorous air enters the nasal cavity through the open orifices, but is not carried throughout it *in motion*.

[TO BE CONTINUED.]

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AN IMPORTANT REPORT.

The Committee of the Saint Louis Medical Society appointed to investigate the dispensaries and clinics in this city made three reports: the first dealt with the evils of medical charity abuse in general terms; the second pointed out specifically the names of the offenders and was accompanied by evidence; and the third contains recommendations for the correction of existing evils. We give herewith all of the text of the second report, and in our next issue will present the third report.

The Second Report (Adopted Without a Dissenting Vote).

ST. LOUIS, May 22, 1897.

To the St. Louis Medical Society:

In bowing to the will of the St. Louis Medical Society the committee is forced to believe that the individuals desiring the charges more personal and specific are conscientious and sincere. The committee had every reason to suppose that the subject matter, contained in the original report, was sufficiently explicit and convincing, in that it directed the attention of the medical profession to the existing gross evils and abuses threatening its welfare. It stated that among the many causes, direct and indirect, of the numerous medical sins, the medical college is the chief malefactor. No one denies that the medical profession owes much to the medical

schools. They have accomplished very good work in the past. But the balance is not altogether on one side. The pendulum is beginning to swing to the other extreme, and the medical profession, deserving, will demand better, fairer treatment at their hands. Unfair and untruthful inducements, expressed and implied, are held out to the unsuspecting, unsophisticated, unprepared, prospective student to enter an overcrowded profession, to which are added every year increasing badly equipped graduates to make the competition more ruinous and demoralizing. The committee was told it might—it was expected, in fact, to exercise a broad and comprehensive latitude in this investigation. When the various abuses with their causes are reviewed, behold a cry goes up that the subject of investigation was not medical colleges, but clinics and dispensaries; what have medical colleges to do with the report? the object being to side-track the cause of all of them—the medical college. It was even stated on this floor that the medical colleges were all right. Ye shades of Æsculapius and Hippocrates! How can any one, unprejudiced, utter such sentiments? How any one can fail to see that they are the *fons et origo* and subterfuges for existing troubles, is past human ken. Not only must the colleges in this city have clinical material, but they must have revenue to meet expenses. Even though a sufficient number of indigent may apply, they do not always possess the humble 25 cts., and almost never the requisite additional aristocratic 25 cts. extra, which helps to swell the superintendent's graft.

In the name of all that is honest and logical, the committee would like to know how it can investigate evils, unless it has the opportunity of discussing their most fruitful source? It claims to-night, more strenuously than was emphasized in the first communication, that the greatest corruptor of the profession is the medical college, which furnishes the greatest, the most injurious, number of clinics. What institutions are guilty of the largest number of infractions of the code? From what source do the most unfriendly acts to the medical profession emanate? The question has been asked, "What is the necessity for so many dispensaries unconnected with the colleges?" So common are they that the city will be soon designated the city of clinics, with that of mounds, as a matter of course. The answer to the above question is at hand. There is no more necessity for them than any others. They are, however, good mediums for advertisements. What is the first thing a doctor does when he comes to town? To connect himself with some clinic or dispensary. Why? Because it pays in advertising, in making acquaintances, in obtaining a clientele. It is just, equitable and reasonable that the same rules that regulate and apply to individuals should govern the actions of bodies of men. The sooner the medical profession realizes and acts upon this principle, the quicker will some of the abuses and misuses be corrected. Perhaps there is a feeling that some are more guilty than others, and that the degrees of sin should be pointed out. *In order to place the guilt where it properly belongs, the committee is willing to file this supplemental report, in which they make specific charges against the following named institutions, with a "bill of particulars":*

I. The Mayfield Sanitarium sends posters throughout the country and has an agent that travels in its interests, advertising the principal and his institution.

“The Missouri Medical College is further guilty of issuing and distributing cards with the word ‘free’ and names of doctors upon them, and having signs with the word ‘free’ in bold relief; particularly a unique sign,

ALL PATIENTS
 desiring to be treated AT ONCE
 CAN BE ACCOMMODATED BY
 SECURING
SPECIAL TICKETS!
 —FROM—
 DR. SAY.
Price 25cts. a Week.
 Alle Patienten, welche gleich
 behandelt zu werden wünschen
 können sich eine Special-Karte
 beim Dr. Say sichern.
 Preis 25 Cents die Woche.

The original card measures about $2\frac{1}{2} \times 3\frac{1}{2}$ feet.

posted in conspicuous places, halls, corridors and waiting-rooms, to the effect that by paying 25 cents extra immediate attention will be given.’

II. The Missouri Baptist Sanitarium has "free" printed on its signs and cards with the names of superintendent and house physician. It has three agents or runners who canvass the country, distributing cards or posters with the names of forty-five of the "best" doctors of the city; the doctors whose names appear on the cards being equally guilty. By what right or justice can this be carried on? Under the cloak of religion?

III. The St. Louis Baptist Hospital distributes dodgers or posters with names of doctors of the medical staff, advertised as specialists. In some respects this medium for advertising is more valuable than the preceding; it is more than doubly so when the same name occurs in the lists of both religious havens of rest.

IV. The Marion-Sims College of Medicine is guilty of using the word "free" on signs and cards, and distributing the same, with the names of the various doctors.

V. The Barnes Medical College is on the list for using the word "free" in advertising its dispensary.

VI. The St. Louis Medical College is guilty of treating applicants free who are able to pay. It is asserted that about 500 surgical cases, between 700 and 800 eye cases, and about

ST. JOHN'S HOSPITAL,

Twenty-third Street, between Olive and Locust Streets.

CLINIC FOR DISEASES OF WOMEN.

Daily at 3 P. M. (Sundays Excepted.)

CLINICAL PROFESSOR:

A. V. L. BROKAW, M. D.

CLINICAL ASSISTANT:

F. A. TEMM, M. D.

No. _____ Date _____ Page _____

Name _____

Always Bring This Card With You.—Bringen Sie diese Karte immer mit.

A Specimen Clinic Card.

The use of such cards is condemned by the St. Louis Medical Society.

700 genito-urinary cases are treated every week. Connected with this institution is the St. Louis Free Midwifery Dispensary, which is advertised on cards and elsewhere as "free."

VII. The Western Polyclinic uses the word "free" on signs and cards; the latter being distributed in the community.

VIII. St. John's Hospital or Infirmary is guilty of issuing and distributing cards with the word "free" and the names of the doctors printed thereon. It is claimed that patients have been sent to private offices and fees have been accepted by doctors in attendance.

IX. The Missouri Medical College is guilty of the grossest breaches of the medical code. It is the greatest offender against the well-being of the medical profession in particular, and the community in general, in treating patients well able to pay, thereby encouraging pauperism, not of the laity, but of the doctor. It is bad enough as outlined in the preceding facts and as stated in a former communication, but the situation is more execrable in this institution, as absolutely no care is taken to weed out the worthy indigent and needy from the well-to-do and rich. So long as 25 cents is paid by the one and an extra quarter by

the other for precedence, the thriving nuisance will continue. Attention has been called to these abuses time and again, but the only satisfaction vouchsafed to a long-suffering profession is that the college could not yet afford to introduce a change. The Missouri Medical College is further guilty of using and distributing cards with the word "free" and names of doctors upon them, and having signs with the word "free" in bold relief; particularly a unique sign, posted in conspicuous places, halls, corridors and waiting-rooms, to the effect that by paying 25 cents extra immediate attention will be given. Some of the evidence of the above was submitted to the Society at the last meeting.

X. The Beaumont Hospital Medical College is guilty of advertising its clinics "free," the same appearing upon the outside of the building, and also of issuing cards upon which are the words "free" and the names of the doctors.

O'FALLON DISPENSARY,

1814 LOCUST STREET,

ST. LOUIS.

OBSTETRIC OUT-CLINIC.

(FREE)

Patients expecting to be confined
can get all necessary treatment at their
homes by making application to the
dispensary physician.

TELEPHONE:

St. Louis Free Midwifery Dispensary,

No. 955.

"Free Midwifery" Card of the St. Louis Medical College.

No doubt there are other offenders, but the committee believes the above is sufficient to warrant some kind of action being taken by this honorable body. The committee does not wish it understood that the above are all the facts that they have in their possession—by no means. There is more material which, however, could not be presented, as the authorities do not wish their names mentioned for reasons given in the preceding report. Perhaps the members will not consider it out of place to call attention to the many complaints against the city dispensary and its branches. It is claimed that in these institutions abuses and evils exist, militating not only against the medical profession but the public in general. The main object for which they were established was to succor the poor and needy. It is claimed it has been diverted from that purpose; for people well able to pay receive treatment and are directed to go to special private offices. Many a case is rushed there, whether he will or no, who has been desirous of going home and having his own physician summoned in attendance.

Now, as to the remedy. The committee has none, nor has it even any suggestions. It feels that to offer any would be outside its scope. It would not be a bad idea for those who are in the business to wear some garb or uniform, such as perhaps are donned by race-track surgeons or doctors, so as to designate their calling.

The committee does, however, in no uncertain tones, affirm that the

medical profession has deteriorated, and unless a halt is called, instead of being looked upon as a high and noble calling, to be a member of which is a coveted honor, it will become a by-word and a stench in the nostrils of the community. Efforts are being made in other cities to correct and control the diseases of the body medical by legislation. The treatment rests with the profession. It is a difficult problem to solve.

The Mayfield Sanitarium



DEAR BRETHREN: Please pardon this little draw on your time. Our hearts are so full of gratitude to God and our dear brethren, who have so nobly come to our help in our new and what seemed hazardous undertakings, that we feel that we just must tell you something of what God has already done for us, and what He seems to be inviting us to do.

First. We have just completed our new and beautiful Sanitarium, a cut of which is at the head of this column, at a cost all told of \$48,111.00, and have paid all this but \$14,000.00 which runs five years at 6 per cent. The building is beautifully furnished and furnishing paid for. We entered the third story the 15th of September, and from that time the house has been full or nearly so, the most of the

But before writing will you pray earnestly for divine guidance and then tell us whatever may be in your heart. We have near a hundred Surgeons, Special lists and Physicians on our staff. We deemed it fit and proper to make up our staff of Baptists and Protestants. At a banquet given Physicians and Surgeons last evening in the chapel, the methods for enlarging the work in the near future were enthusiastically endorsed, great stress and emphasis being given to our purposes of establishing a home for the treatment of consumptives away from and separate from this building.

Earnestly soliciting your sympathy and co-operation, we are yours for Christ and suffering humanity,

W. H. MAYFIELD.

A. F. BAKER.

912 Taylor Avenue.

Feb. 20, 1897.

Specimen Literature of the Mayfield Sanitarium.

In conclusion, the committee feels that this representative body, the flower of the medical profession in this community, should place itself upon record in condemning the misuses and abuses pointed out. Believing that it has performed its disagreeable, thankless duty to the best of its ability, however imperfect it may be, it desires to be discharged.

Respectfully submitted,

ROBERT M. FUNKHOUSER,

ROBERT H. FINLEY,

P. D. CONNOLLY.

RELIGIOSITY RUN MAD.

The posters issued by the Missouri Baptist Sanitarium, in addition to containing the names of forty-five "best" doctors of St. Louis, show how intimately medicine and religion are connected at the present day. In ancient days the priests were the law-givers, medicine men and general promoters of the community. Is it possible that we will revert to that order of things? Read the following and then answer the question, if you can:

"Every morning after breakfast we meet to worship God. The Scriptures are read and expounded; the praises of God are sung and prayer is offered. Every Lord's Day afternoon a general Sanitarium prayer-meeting is held in our chapel, when the public is expected."

STAFF OF THE BAPTIST SANITARIUM.

From the interesting and instructive literature of the Missouri Baptist Sanitarium, which has been scattered broadcast among the laity, we are able to settle a long-disputed question, viz.: WHO ARE THE "BEST" DOCTORS IN ST. LOUIS? Following is the "medical staff" of the aforesaid institution:

Dr. G. BAUMGARTEN,	Dr. C. J. ORR,	Dr. J. B. JOHNSON,
Dr. J. P. BRYSON,	Dr. W. B. OUTEN,	Dr. F. J. LUTZ,
Dr. E. C. BURNETT,	Dr. M. H. POST,	Dr. W. G. MOORE,
Dr. N. B. CARSON,	Dr. T. F. PREWITT,	Dr. F. D. MOONEY,
Dr. I. H. CADWALLADER,	Dr. P. G. ROBINSON,	Dr. PHILIP SKRAINKA,
Dr. WM. CONRAD,	Dr. E. W. SAUNDERS,	Dr. G. SLUDER,
Dr. C. H. DICK ON,	Dr. J. B. SHAPLEIGH,	Dr. T. O. SUMMERS,
Dr. W. B. DORSETT,	Dr. W. E. FISCHER,	Dr. H. N. SPENCER,
Dr. C. R. DUDLEY,	Dr. FRANK R. FRY,	Dr. A. J. STEEL,
Dr. J. H. DUNCAN,	Dr. E. H. GREGORY,	Dr. JUSTIN STEER,
Dr. FAYETTE EWING,	Dr. JOSEPH GRINDON,	Dr. H. TUHOLSKE,
Dr. H. H. MUDD,	Dr. W. C. GLASGOW,	Dr. P. Y. TUPPER,
Dr. H. G. MUDD,	Dr. F. A. GLASGOW,	Dr. G. M. TUTTLE,
Dr. J. C. MULHALL,	Dr. W. A. HARDAWAY,	Dr. B. A. WILKES,
Dr. E. N. NELSON,	Dr. C. H. HUGHES,	Dr. T. C. WITHERSPOON.

Literature containing the above list has been distributed among many laymen.

[EDITORIAL NOTE.—We believe some of these doctors are innocent; we also believe others are guilty of a breach of the code, knowing that the circulars were to go to the laity. *Somebody* is responsible. Any gentleman who desires to do so can explain his views and position in our next issue.—ED.]

WHAT THE COMMITTEE SAID ABOUT THE MISSOURI
MEDICAL COLLEGE.

"The Missouri Medical College is guilty of the grossest breaches of the medical code. It is the greatest offender against the well-being of the medical profession in particular, and the community in general, in treating patients well able to pay, thereby encouraging pauperism, not of the laity, but of the doctor."

Who are the members of the faculty of the Missouri Medical College? Here is the list as found in the fourth edition of Polk's Medical Directory:

PROFESSORS.

- P. GERVAIS ROBINSON, M. D., LL. D., Professor of Practice of Medicine, Clinical Medicine and Hygiene, and Dean of the Faculty.
 J. K. BAUDUY, M. D., LL. D., Professor of Psychological Medicine and Diseases of the Nervous System, and Medical Jurisprudence.
 CHAS. E. MICHEL, M. D., Professor of Ophthalmology.
 H. TUHOLSKE, M. D., Professor of Clinical Surgery and Surgical Pathology.
 T. F. PREWITT, M. D., Professor of Principles and Practice of Surgery, and Clinical Surgery.
 FRANCIS HEMM, Ph. G., Professor of Chemistry, and Director of the Chemical Laboratory.
 JUSTIN STEER, Ph. B., M. D., Professor of Materia Medica, Therapeutics and Clinical Medicine.
 W. A. HARDAWAY, A. M., M. D., Professor of Diseases of the Skin and Syphilis.
 H. N. SPENCER, A. M., M. D., Professor of Diseases of the Ear, and Vice-Dean of the Faculty.
 WM. C. GLASGOW, A. B., M. D., Professor of the Practice of Medicine, Diseases of the Chest, and Laryngology.
 H. M. WHELPLEY, Ph. G., M. D., F. R. M. S., Professor of Physiology and Histology, and Director of the Histological Laboratory, and Secretary of the Faculty.
 A. J. STEELE, M. D., Professor of Orthopedic Surgery, Treasurer and Registrar of the Faculty.
 W. HUTSON FORD, A. M., M. D., Professor of Obstetrics and Gynecology.
 A. V. L. BROKAW, M. D., Professor of General and Descriptive Anatomy, and Demonstrator of Operative Surgery.
 E. W. SAUNDERS, M. D., Professor of Pediatrics and Clinical Midwifery.
 HON. SELDEN P. SPENCER, A. M., Ph. D., LL. B., M. D., Professor of Legal Medicine.

CLINICAL PROFESSORS.

- H. W. HERMANN, M. D., Clinical Professor of Diseases of the Nervous System and Electro-Therapeutics.
 D. C. GAMBLE, M. D., Clinical Professor of Diseases of the Ear.
 F. C. AMEISS, M. D., Clinical Professor of Gynecology.

ASSISTANT PROFESSORS.

- W. S. BARKER, Ph. B., M. D., Assistant Professor of Diseases of Children and Clinical Midwifery, and Chief of Children's Clinic at the College Dispensary.
 J. C. FALK, Ph. G., M. D., Assistant Professor of Materia Medica and Pharmacy.

LECTURERS, DEMONSTRATORS AND INSTRUCTORS.

- H. A. L. ROHLFING, Ph. G., M. D., Lecturer on Bacteriology and Pathology, Microscopist to the Faculty, and Curator of the Museum.
 L. M. PERKINS, B. S., M. D., Lecturer on Minor Surgery and Bandaging.
 HENRY S. BROOKES, Ph. G., M. D., Lecturer on Clinical Medicine, and Assistant in the Medical Clinic at St. John's Hospital.
 HARTWELL N. LYON, M. D., Chief of the Dermatological Clinics.
 H. N. CHAPMAN, M. D., Clinical Instructor in Midwifery.

FACULTY OF THE ST. LOUIS MEDICAL COLLEGE.

It may be interesting to our readers, particularly those far away from this city, to know the names of the members of the faculty of the St. Louis Medical College. It will be remembered that the Committee on the Abuse of Medical Charity said of the college:

"The St. Louis Medical College is guilty of treating applicants free, who are able to pay."

FACULTY OF THE ST. LOUIS MEDICAL COLLEGE.

J. B. JOHNSON, M. D., Professor of Principles of Medicine.
 E. H. GREGORY, M. D., Professor of Principles and Practice of Surgery.
 G. BAUMGARTEN, M. D., Professor of Practice of Medicine.
 HENRY H. MUDD, M. D., Professor of Clinical Surgery.
 W. E. FISCHER, M. D., Professor of Clinical Medicine.
 ROBT. LUDEKING, M. D., Professor of Diseases of Children.
 JOHN GREEN, M. D., Professor of Ophthalmology.
 JAMES M. SCOTT, M. D., Professor of Obstetrics.
 JOHN P. BRYSON, M. D., Professor of Genito-Urinary Surgery.
 FRANK R. FRY, M. D., Professor of Diseases of the Nervous System.
 HENRY SCHWARZ, M. D., Professor of Gynæcology.
 FRANK A. GLASGOW, Professor of Clinical Gynæcology.
 HARVEY G. MUDD, M. D., Professor of Osteology and Regional Anatomy.
 PAUL Y. TUPPER, M. D., Professor of Descriptive Anatomy.
 E. M. SENSENEY, M. D., Professor of Therapeutics and Materia Medica.
 CHAS. B. SANGER, Ph. D., Professor of Chemistry.
 NORMAN BRUCE CARSON, M. D., Professor of Clinical Surgery.
 JOS. GRINDON, M. D., Professor of Dermatology.
 JOHN B. SHAPLEIGH, M. D., Professor of Otology.
 SIDNEY P. BUDGETT, M. D., Professor of Physiology and Pathology.

WHAT ARE YOU GOING TO DO ABOUT IT?

This is the question some of the Big Wigs are asking. So far as the committee is concerned, the third report expresses its views and will be presented in our next issue. So far as the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER has any influence, its power will be directed against the abuse of medical charity, both here and elsewhere; however, we will see to it that the local nest is cleared of filth before our efforts are directed elsewhere.

We ask our country subscribers if it is right that they should send cases for treatment to doctors in this city who are known to foster the abuse of medical charity? Can you afford to send students to those colleges where the dispensary doctors habitually treat, free of charge or for a nominal fee, patients well able to pay? Can you afford to patronize a hospital which employs drummers to solicit patients? Are you willing to assist the ethical members of the St. Louis Medical Society in stopping an evil of enormous proportions, and which, if unchecked, will turn a profession into a mere trade?

By advising medical students to keep away from the offending colleges, and by your own example in refusing to send patients to the hypocritical city doctors who abuse medical charity, our friends in the country can assist the medical press in bringing order out of chaos and justice out of iniquity. Are you with us?

GOVERNOR TANNER ON OSTEOPATHY.

On the 10th inst. Governor John R. Tanner, of Illinois, vetoed the bill to regulate the practice of osteopathy (whatever that may be) in Illinois. Every friend of the medical profession must rejoice at this action. The Governor's reasons are as follows:

"The act is clearly in the nature of class legislation, in that it discriminates in favor of one particular method of treating diseases of the human body, and against all other methods. To allow this measure to become a law would be demoralizing to the practice of medicine

and treatment of diseases of the human body, and to a large extent destroy the usefulness of the State Board of Health. The act would open wide the doors of Illinois to incompetent, dishonest and unscrupulous adventurers, calling themselves practitioners of osteopathy, and there would be no remedy.

"The more meritorious the system, the better it can afford to stand on a perfect equality with other recognized systems, and willingly subject itself to the control of the State Board of Health, under the general law.

"If by my veto I was subjecting the adherents of the new system to any undue hardships, or depriving them of any rights enjoyed by others engaged in the laudable business of healing the afflicted, I would hesitate, but I am not. The system or method being new, comparatively untested, and very indefinitely understood, there is all the more reason for the general supervision and control of the State Board of Health, without which I am unwilling to give my approval, and, therefore, return the bill to be filed with my objections.

(Signed)

"JOHN R. TANNER, Governor."

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter V.—Continued.

THE HITCHING-POST.

Dr. Nextstreet and Dr. Newcomer, meeting:

Dr. New.—How are you, Dr. Nextstreet? What is the matter? Why do you look so mad?

Dr. Next.—Mad!!! Yes, I am *angry!* My landlord will not put a hitching-post at my curbstone; I have a patient who comes in from the country, and he cannot hitch his horse anywhere around here. There ought to be a hitching-post!

Dr. New.—What use is it to get angry about that? Buy a cedar post and have it put in, or put it in yourself; that is what I should do to accommodate my patients.

Dr. Next.—I'll be blanked before I do!

A few days later, the hitching-post loomed up proudly before Dr. Nextstreet's residence, and to it was tied a spirited horse attached to an elegant buggy.

Dr. Newcomer, coming around the corner, encounters Dr. Nextstreet leaving his house:

Dr. New.—Good-morning; I am glad to see you have the hitching-post and a fine turn-out; you look mad again, what is the matter now?

Dr. Next.—Mad!!! Yes, mad like hell! I followed your advice; I wish I had not done so; I have no horse and buggy; I put that post in for my patient who comes from the country; it cost seventy-five cents, and just think of it, Mr. Banker, next door, has been very sick; his doctor lives on Washington avenue; he comes up here every morning, and sometimes twice a day, and has the insolence to hitch his horse to my post, right at my door; it is enough to make *anybody* mad!

Dr. New.—Look here, my dear doctor, what is the use for one to com-

plain all the time? It makes life miserable to be seeing nothing but clouds and shadows; be cheerful and look at the sunny side. You are doing well enough, why envy him who has a horse and buggy, and lives in luxury? You do not know his sorrows; besides, envy is a kind of praise. Do not be jealous of him who has more than you, but be thankful that you are better situated than the poor fellow down the street, who must sell his books to pay his rent; I should rather enjoy letting my colleague have the accommodation of the hitching-post.

Dr. Next.—*You* might, but not I.

Dr. New.—Supposing you invent an automatic hitching-post, which would disappear to parts unknown when any but your patient attempted to tie his horse to it.

Dr. Next.—You are a case.

Dr. New.—One more word: *how* fortunate for the poor hitching-post that the medical code cannot reach it. Good-bye.

Dr. Nextstreet is still kicking.

TITLES.

What about it? Dr. Newcomer wrote a pamphlet on orthopædic surgery, reporting several interesting cases; the title-page bore his name and well-earned titles, giving also the names of the medical societies of which he was a fellow; several hundred copies of the pamphlet were distributed amongst the members of the medical society.

At the next meeting, under the head of extraordinary business, one venerable practitioner demanded the floor, pamphlet in hand, unwilling to wound, yet ready to strike, and spoke in this wise: "Mr. President and gentlemen of this honorable body, this glorious and *charitable* profession. I received this pamphlet from Dr. Newcomer, with his name followed by his titles on the cover page; this is unprofessional conduct—it is against the code, which forbids the use of titles; I am *shocked*; some one should bring charges against the young member."

(The following week Dr. Newcomer celebrated his silver wedding; what a satisfaction to remain young.)

Dr. Newcomer was not present at this meeting, and a dozen sensible doctors arose to defend the absentee, calling attention to the fact that the code says nothing about the use of titles rightfully belonging to an author. Authors of books give their titles, the chair they hold in a college, "Prof. of —," also if consultant to any hospital, the membership with local and foreign societies, "Pres. of Soc.," "Editor of Jour.," etc.; they are given at the heads of journals and it is legitimate. Recognized as a custom, it settled the grievance of an offended codeman who never writes.

A WOULD-BE PRESIDENT.

Dr. Nervo was a well-educated man, a writer of no small merit, a brilliant debator, and withal a dignified gentleman, possibly inspired with ambition; he was a specialist, and was a member and regular attendant of the medical society; he had faithfully served for a number of years in a minor capacity in one of our colleges, waiting for the promotion which came not, until a new college was started for the edification of the rising generation, and with which came his promotion to a full professorship; at present he is president of a scientific educational institute; perseverance wins in the end.

Dr. Nervo was desirous of becoming president of a medical society; to this end, his friends proposed his name four or five times, with crushing failure.

Finally, with reinforced determination and confidence, he pulled every string, set every wheel in motion, and renewed the attack. He petitioned many of his friends to vote for him, at *least* on the first ballot, and not having time to interview all of them, addressed the others in writing; as a crowning effort, one week previous to the election, he read a lengthy article teeming with newly-coined words before the medical society.

Dr. Nervo, with all his learning and experience, had no political tact; ability alone elects presidents of the medical society.

Behold! The election came off, and after several ballots our specialist was once more defeated; he appeared to take it in good part, but thereafter, he was rarely seen at the medical society.

What was the cause of the continuous disappointments of this well-deserving man, whose merits received no recognition?

Solution.—Dr. No. I. said: "Well, Nervo has again been defeated; he should have had the presidency; I did not vote for him for the simple reason that he asked me to do so; I shall vote for no man who asks me."

Dr. No. II. said: "Dr. Nervo would have made a good president; I should have voted for him, but I received a note from him soliciting my support, so I voted against him."

There were more who expressed themselves thus: "I am very sorry that Dr. Nervo was not elected—he is an excellent man; if he had only been a little more courteous and spoken to me on the subject or written me a note, I should have voted for him. He slighted me and I paid him back."

Ó, human nature thou art queer!

Like Tom Brown in 1704,
 "I do not love thee, Dr. Fell,
 The reason why I cannot tell,
 But this alone I know full well,
 I do not love thee, Dr. Fell."

This seems to be the music in general, in large cities; the country is not so unreasonable.

[TO BE CONTINUED.]

Central Missouri Physicians.—The Central Missouri District Medical Society met at Jefferson City, Mo., June 3, 1897. Sixteen members of the association were present. The president, Dr. R. E. Young, of this city, presided. The principal feature of the meeting was the reading of papers by Dr. R. E. Young and by Dr. Carl Bark, of the Marion-Sims Medical College of St. Louis. This association was organized here a month ago and has twenty members. The next meeting will be held July 5th.

In Preparation for Early Publication.—An American Text-book of Genito-Urinary and Skin Diseases. Edited by L. Bolton Bangs, M. D., Late Professor of Genito-Urinary and Venereal Diseases, New York Post-Graduate Medical School and Hospital, and William A. Hardaway, M. D., Professor of Diseases of the Skin, Missouri Medical College.

HISTORICAL SKETCH.

THE SCHOOL OF SALERNUM.

By JAMES MOORES BALL, M. D., of St. Louis.

THE school of Salerno, so justly celebrated during the Middle Ages for the skill of its physicians and surgeons, forms a connecting link between ancient and modern medical history. The city of Salerno, situated on a beautiful bay, in the midst of healthful surroundings, at an early date became a favorite resort for the sick. Although this city was the seat of a bishopric in the sixth century, and of a Benedictine monastery in the seventh, yet the renowned medical school, although the offspring of monasticism, was purely a secular institution.

With the most skillful physicians in all Christendom; with a location unexcelled, lying in the direct path of valiant hosts of Crusaders; with a salubrious climate and ample means for rest and recreation, it is not surprising that the medical school of Salerno should have attained a great prosperity. Here, even in the time of Horace, the Romans came because the air was more bracing than that of Baia. Here the wounded warrior, fighting the battles of Christ in Palestine, could obtain deserved rest, receive the highest professional skill, and gain a new strength from ocean breeze and bracing mountain air. Here came the kings, princes and potentates of earth to profit by advice. Here, in 1100, came Robert, Duke of Normandy, son of Conqueror William, for surgical treatment of a wounded arm. Here, for eight hundred years, medicine was taught to thousands of thirsty souls. Here the impress of medical progress was so strongly felt that the city called itself "*Civitas Hippocratica*," and thus its seals were stamped. Here, in the eleventh, twelfth and thirteenth centuries, students were gathered from all parts of the civilized world. Here Roger, King of Sicily, and Williams I. and II., came to study medicine. Here medical diplomas were first issued to waiting students, who took a sacred oath to serve the poor without pay. Here, with a book in his hand, a ring on his finger and a laurel wreath upon his head, the candidate was kissed by each professor and told to start upon his way. Here women were professors and vied with men in spreading the doctrines of our art.

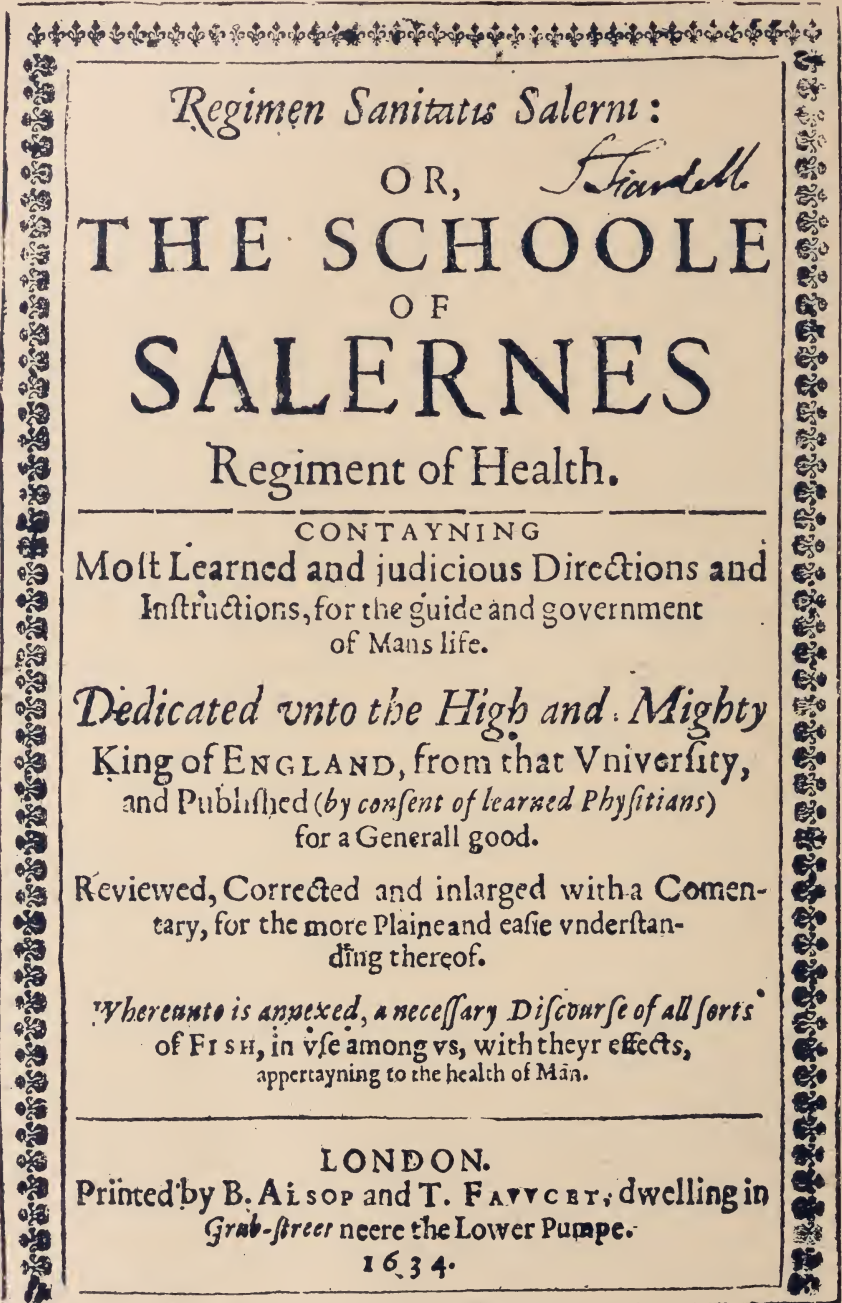
The present condition of the city may be judged by the following lines, which are from the pen of Valentine Mott:

"In passing onward into Calabria from Pompeii, we stopped for the night at Salerno, on the lovely bay of that name. Our interest was very much excited in this place by the recollection that it was here where, many centuries since, was begun what afterward became the most renowned medical school of Europe; but, melancholy to relate, not a single vestige or relic whatever remains by which to identify or recall the former glories of this small village and of its celebrated university."

The origin of this school, wrapped as it is in the mists of obscurity,

* Mott: "Travels in Europe and the East," N. Y., 1842, p. 145.

has long been a bone of contention among medical historians. Confusion has readily arisen from the proximity of Salerno to the cloister of Monte



Title Page of the Regimen of Health.

Cassino, and from the existence of a medical curriculum in each locality. We can understand the early history of Salerno only by a simultaneous

study of the monkish school of Monte Cassino. An Italian historian of the seventeenth century names as founders of the Salerno school Elinus, a Jew; Pontus, a Greek; Adala, a Saracen; and Salernus, a Latin, each of whom taught medicine in his native tongue. He also states that Charlemagne, in the year 802, transformed the school into a regular college. Freind believes both statements, and says the school was founded about the middle of the seventh century. Renouard ascribes the origin of this school to certain fugitive professors who are supposed to have been driven out of Alexandria when that city was captured by the Saracens, A. D. 640. Meryon says the school took its origin from a band of Norman pilgrims who, returning from a pilgrimage to the East, landed at Salerno, delivered the city from the hands of the Saracens, and established the famous medical school. Baas says: "The time and manner of the founding of the school of Salerno are unknown and uncertain, and on this subject conjectures only can be advanced." Sprengel and Isensee, both learned German writers, attribute the foundation to the Benedictine monks of Monte Cassino; while Haller thinks it was established by the Saracens soon after their conquest of Sicily. Daremberg renounces all these statements and holds the view that the school was the gradual outgrowth of the times. Handerson, who has given an exhaustive account of the school of Salerno, says: "Each of these views is open to more or less criticism. Charlemagne could not have organized a college at Salernum in the year 802, for (as Giannone proves) his authority over the duchy of Beneventum, never more than nominal, was at this period entirely rejected. The foundation of the school by fugitives from Alexandria is entirely conjectural; its Arabian origin has little evidence in its favor, save that for more than a century the duchy of Beneventum was ravaged by the Saracens, either as enemies or allies of its princes." Malgaigne and Daremberg assert that there is no evidence of any trace of Arabian medicine in Salernum prior to the close of the eleventh century. It was at that period that Constantine, the African, became a teacher in this school. All historians are agreed that the monastery exerted a potent influence upon Salernum. There can be no doubt that the establishment at Monte Cassino could early boast of a medical school, and that many wonderful cures were credited to the monk-physicians.

As regards the history of the monastery there is no serious disagreement. In the year 528, A. D. (or, as stated by some authors, 529), St. Benedict, of Nursia, the founder of the celebrated Benedictine order, withdrew from the vices and jealousies of the priests of the Anio, and secluded himself on Mt. Cassino. At that time this locality could boast of a temple erected to Apollo, and a grove sacred to Venus. The exhortations of St. Benedict were so powerful that all inhabitants accepted religion and destroyed their ancient pagan shrines. Soon two chapels were erected to St. Martin and St. John the Baptist, while farther up the hill a monastery arose. St. Benedict required the monks of his order to cure the sick and treat them by prayer and Christian conjurations, but all public discussion and teaching was forbidden. Many miraculous cures were recorded as having been performed by this saint. Thus we find that in the year 1022 A. D., Henry II., of Bavaria, emperor of Germany, visited the monastery to obtain relief from a vesical calculus. By some writers it is stated

that he was cut by St. Benedict himself; while others assert that the royal patient fell into a deep slumber, during which the stone was removed by the saint in ghostly form and, on awakening, the wound was found to be healed. The rule which forbade public instruction must have been violated since the Abbot Bertharius, toward the close of the ninth century, wrote two books on medical subjects, and Sprengel claims that he was not the first of the monastic authors. As early as the tenth century the fame of this monastery as a medical center had spread through many kingdoms, and monks came from far distant lands to study medicine here. Desiderius, who was abbot of Monte Cassino, A. D. 1058-86, was learned in music and in medicine. Under the name Victor III., he ascended the papal chair in the year 1086. It is said that he founded a new hospital in connection with the monastery, and wrote four books on the miraculous cures wrought by St. Benedict. As we shall see later, it was in the quietude of this monastery that Constantine, the African, the most celebrated Christian physician of his age, composed the numerous medical works which bear his name. It is not unreasonable to suppose that the school of Salerno was founded by the monks of Monte Cassino. The fact that Salerno is only four miles distant from the monastery lends credence to this view. The vexed question of the origin of this school is disposed of by Sprengel, in these words: "As early as the eighth century this cloister was considered by the Italians and French to be one of the best; and countless monks came from the farthest provinces of France to Monte Cassino to pursue their studies. It was the monks of this cloister who practiced medicine in Salerno, finally settled in that city, and bound themselves by an obligation to teach the art of medicine to others."

What Bologna was for law and Paris for philosophy, the school of Salerno was for medicine. In this school, as in all medical institutions of the Middle Ages, the works of Hippocrates and Galen were industriously studied, commented on and explained. In a bull issued by Clement V. (1309), the text-books to be used in teaching medicine are enumerated. Another document of earlier date (1270-74) giving the conditions of a license in medicine and the books studied in the University of Paris, shows the regulations were everywhere the same. The volumes used were written in Latin, the works of Hippocrates and Galen having been translated into that language as early as the sixth century. That Latin books continued to be used for several centuries to the exclusion of Greek is evidenced by the fact that Rabelias, who studied medicine intermittently at Montpellier from 1520 to 1530, was the only one of his comrades who had read the works of the Greek physicians in the original. To the writings of the fathers were added other works modern in character—the books of Constantine, the African, who was the great light of Salerno; of John St. Amand; and Nicholas, whose *Antidotarium* was a classic. The works of Constantine were translations from the Arabic of Haly-Abbas and Rhazes.

Constantine deserves more than a passing notice. Born at Carthage, in the early part of the eleventh century, he passed thirty-nine years of his life in the travel and in the study of various sciences and arts among the Babylonians, the Indians, and the Moors. He is said, on the authority of many ancient writers, to have been versed in grammar, dialectics, physics, necromancy, geometry, arithmetic and medicine, as well as the musical art of the

Chaldæans, Arabians, Persians and Egyptians. Returning to Carthage he began to teach the youth of that city. The citizens, however, astounded by the vastness of his knowledge, looked upon him as a magician and sought his life. This is not surprising when we remember that Gerbert and Roger Bacon, both learned men, passed through similar trials. Constantine sought an asylum in Salerno. For a time he was secretary to Robert Guiscard, king of Sicily, but withdrew from the royal service to Monte Cassino, where his days were passed in making translations into Latin of Saracenic works on medicine and philosophy. The works of this author were printed in two volumes at Basel, in 1536 and 1539, respectively.

The education of that day was strictly a book education. Laboratories were unknown, clinical teaching unheard of; and the study of human anatomy occupied no place in the curriculum until the year 1315, when Mundinus, of Bologna, made demonstrations and dissections upon several cadavera. Previous to his time, after the decline of the Alexandrian school of medicine, anatomy had been studied in a practical manner only upon the bodies of the lower animals, such as dogs, apes and swine. The act of Mundinus amounted to a revolution. For centuries before his day the religious precept of the Arabs making dissection a crime had cast a withering influence over European medicine. He threw the first glimmering rays of light into a long period of darkness; and although his treatise on anatomy was a small production, full of errors and difficult to understand, it was, nevertheless, a work which marked a great step toward the goal of scientific knowledge.

A dissection was a rare event. At Montpellier, the statutes of 1340 provide there shall be a dissection once every two years; and, in 1396, it was ordained by Charles VI. that there should be delivered every year to the faculty of medicine, for the purpose of anatomical study, the body of a criminal, "of either sex or of any class, hanged, drowned, or slain in any other manner after legal condemnation." After dissection, the corpse was buried with religious rites. The school of Salerno was never erected into a university. Within a short distance of Naples it became, so to speak, the medical department of the University of Naples, when the latter was founded by Frederick II., in 1224. This enlightened monarch, one of the most interesting figures of mediæval times, was a friend to the medical profession. Himself a zealous student of natural history and comparative anatomy, as his treatise on falconry attests, the Hohenstauffen ruler enacted laws regulating the practice of medicine and surgery within his domains. No person could be admitted to medical instruction unless previously for three years he had studied logical science. No one could practice medicine without first passing an examination at the hands of medical officers at Naples or Salerno. Only after five years of medical study was the candidate entitled to an examination before the medical board. After receiving his diploma, the physician was legally bound to attend the poor without pay. He was expected to visit indigent invalids twice in the day, and, if summoned, once at night. It was his duty to report to the officers of the law all pharmacists guilty of the crime of substitution. The remuneration of physicians was fixed by statute. No surgeon could perform an operation without a previous knowledge of anatomy. Physicians were cautioned against secret association with

pharmacists to defraud patients by exorbitant charges for medicines.

The cost of medicines was subject to statutory regulation. Public pharmacies, whether located in the large cities or conducted in a small way in the monasteries, were required to conform to specific regulations. Negligence in compounding remedies was punished by fine. Every five years a demonstration must be made upon a human cadaver. Physicians and surgeons were required to attend these seances, the first of which was conducted by Mundinus, in 1315, at Bologna. In all things Frederick II. carefully guarded the health of his subjects. He, however, was not the first potentate to promulgate decrees regulating the practice of medicine. As early as the latter part of the eleventh century, Roger, king of Sicily, a descendant of William the Norman, observing the expansion of medical studies at Salerno, issued an edict requiring each person desiring to practice medicine to present himself before a body of royal officials who would pass upon his qualifications. The law here referred to is the earliest known European regulation, passed in mediæval times, governing the medical profession. A similar rule was in operation in Jerusalem in 1090. Under the Roman Empire, as we have seen, physicians were the subject of many enactments.

It was in the year 1240 that Frederick II. confirmed the law of King Roger which was passed in the year 1137, or 1140, and which said that, "Whoever from this time forth desires to practice medicine must present himself before our officials and judges, and be subject to their decision. Any one audacious enough to neglect this shall be punished by imprisonment and confiscation of goods. This decree has for its object the protection of the subjects of our kingdom from the dangers arising from the ignorance of practitioners."

Frederick's law said:

"Since it is impossible for a man to understand medical science, only if he has previously learnt something of logic, we ordain that no one shall be permitted to study medicine until he has given his attention to logic for three years. After these three years he may, if he wishes, proceed to the study of medicine. In this study he must spend five years, during which period he must also acquire a knowledge of surgery, for this forms a part of medicine. After this, but not before, permission may be given him to practice, provided that he pass the examination prescribed by the authorities and at the same time produces a certificate showing that he has studied for the period required by the law." "The teachers must, during this period of five years, expound in their lectures the genuine writings of Hippocrates and Galen on the theory and practice of medicine." "But even when the prescribed five years of medical study are passed, the doctor should not forthwith practice on his own account, but for a full year more he should habitually consult an older experienced practitioner in the exercise of his profession."

"We decree that in future no one is to assume the title of doctor, to proceed to practice or to take medical charge, unless he has previously been found competent in the judgment of teachers at a public meeting at Salerno, has moreover by the testimony in writing of his teachers and of our officials approved himself before us or our representatives in respect of his worthiness and scientific maturity, and in pursuance of this course has received the State license to practice. Whoever transgresses this law, and ventures to practice without a license, is subject to punishment by confiscation of property and imprisonment for a year." "No surgeon shall be allowed to practice until he has submitted certificates in writing of the teachers of the faculty of medicine that he has spent at least one year in the study of that part of medical science which gives skill in the practice of surgery, that in the colleges he has diligently and especially studied the anatomy of the human body, and is also thoroughly experienced in the way in which operations are successfully performed and healing is brought about afterwards."*

By an edict of the French government, promulgated in 1811, this school was closed.

* Puschmann: History of Medical Education.

Instruction was given to female as well as male students, and some of the teachers of Salerno were women. The names of five of them, who were professors of medicine, have been handed down to us. They are: Abella, Mercuriadis, Rebecca, Trotula and Constantia Calenda. Women invaded the law also. In the year 1236 Vitisia Gozzodini held public lectures in Bologna, on the Institutes of Justinian, and appeared in male costume.

Gauthier de Conisi speaks of the practice of medicine by nuns:

“And the world wondered when it did learn
That woman had found a new mission;
When the doctors of Montpellier and Salern (o)
Saw each nun to be a physician.
A fever they knew, a pulse they cou d feel,
And best of all is, *they managed to heal.*”

In feudal times, when fathers, brothers and lovers were gallant knights and oft returned from combat, or tourney, wounded and sore, it was all important that women should be skilled in physic and surgery.

The monks of St. Benedict regarded the evangelist Matthew as their tutelar patron. Relics of the female martyrs, Archelias, Thekla, and Susanna, were employed in the treatment of disease; and as late as the twelfth century Bernard, Abbot of Clairvaux, was invited to Salerno that he might perform miraculous cures upon patients whom the Salernite physicians had failed to relieve.

If any rivalry in medical practice existed between the monk-physicians of Monte Cassino and their brethren in the city, it did not long continue. The city soon overshadowed the cloister in medical reputation. Very early in its history, celebrated rulers and high church dignitaries traveled to Salerno to consult the faculty.

That which, in greatest measure, has added to the reputation of the medical school of Salerno, and has served to perpetuate its name for many centuries, is the celebrated *Regimen Sanitatis Salernitanum*, or, as it was called at a latter date, *Schola Salernitana*. Salernian physicians are mentioned in the annals of the kingdom of Naples as early as the middle of the ninth century. A century later Peter V. (958-969), bishop of Salernum, was described as a man “*medicinæ artis insignis.*” From this time on the fame of Salernum as a medical center steadily grew until its zenith was reached in the thirteenth century.

The chief literary works emanating from the school of Salerno, which have been preserved to our day, are two in number, viz.: the *Compendium Salernitanum* and the *Regimen Salerintana*. The former was discovered in MS. by Prof. G. E. T. Henschel, of the University of Breslau, in 1837. The latter was widely celebrated during mediæval times, and no less than two hundred and forty different editions were printed between the years 1474 and 1846. For centuries it served as a *vade mecum* for the physicians of all lands. Written originally in Latin, it has been translated into English, French, German, Italian, Irish, Polish, Provençal, Bohemian, Hebrew and Persian.

This medical poem can boast of a multitude of titles. Thus the different names attached to various Latin editions of the work are: *Regimen Sanitatis Salerni*, *Schola Salernitana*, *De Conservanda Bona Valetudine*, *Lilium Sanitatis*, *Flos Medicinæ*; while the English titles run as follows: *The Englishman's Doctor, or the Schoole of Salerne; The Schoole*

of *Salerne's Regiment of Health*. From a work of 364 lines (first edition probably printed in 1474, with commentaries of Arnold of Villanova) the poem has grown through the ages to the size of several thousand lines. From various MSS. and editions, De Rienzi collected not less than 3,520 lines, some of which are of comparatively modern date, although many were taken from Macer Floridus or Ægidius of Corbeil.

This work is a collection of dietetic precepts, written in Leonine verse by the faculty of Salernum, and addressed to Robert, Duke of Normandy, who was the son of William the Conqueror. On his return from the Crusades, about the year 1099, Robert stopped in Salernum to be treated for a wound of the arm received at the siege of Jerusalem. The physicians decided that the wound was poisoned, and that it would be necessary to suck out the noxious substance. No one could be found, however, who was willing to undertake a procedure so fraught with danger to the operator. Robert had recently married a noble lady—Sibyl, the daughter of the Count of Conversana. She desired to extract the virus, but Robert would not consent. The heroic lady waited until her husband was in a deep slumber, and sucked the poison from the wound. She was rewarded for her heroism by seeing her husband recover, and she herself suffered no harm. Robert sojourned a considerable time in the vicinity of Salernum, and departed for England only on receiving news of the death of his brother, William II., whom he hoped to succeed upon the throne. The wish of Robert, however, was never fulfilled; but, notwithstanding this fact, the *Regimen* was dedicated to him as king, it being supposed by the faculty that he had ascended the throne. The rhythmical prescriptions offered the English prince by the school of Salernum assisted in extending the fame of this city and the adjacent monastery to the most remote parts of Europe.

There is a difference of opinion regarding the authorship of this work. It is supposed by Haller that these verses were not written by the faculty of the school, but that they are the work of a celebrated physician, John of Milan, who was president of the school of Salernum. Daremberg, however, who has studied this question with great thoroughness, considers it the work of several medical rhapsodists. Whether the product of one or many minds, the *Regimen* exerted a potent influence upon the medical practitioners of the Middle Ages. Some writers have believed that the *Regimen* was dedicated to Edward the Confessor, and that he was the king referred to in the text. This, however, is a matter of minor importance.

Of the Salernite poem not less than one hundred and thirteen editions were printed in Latin; and it is stated on the authority of Haeser that eighty-one manuscripts of the work are now known to exist. Five English translations have been published—the first by Thos. Paynell, an English clergyman, in 1530; the second by John Harington, issued in 1607, bore the title, *The Englishman's Doctor, or the Schoole of Salerne*. The third edition is said by Handerson to have been issued by R. H(olland), London, 1649, under the name, *Regimen Sanitatis Salernitanum, or the Schoole of Salerne's Regiment of Health*, and consisted of text with metrical translation. Possibly there is a mistake about this, for I possess a copy with the same title, London, 1634, to the preface of which the initials "R. H." are appended. In 1830, Alex. Croke, Oxford, issued

an edition with Latin text, old English translation, historical notes and introduction. The last edition, entitled *Code of Health of the School of Salernum*, by John Ordnonaux, LL. D., Philadelphia, appeared in 1871. This author mentions an unpublished translation, made in 1575, the MS. of which is in the library of Corpus Christi College, Oxford.

The nature of this celebrated medical poem may be judged by the following extracts, which are taken from the London edition of 1634, translated by (R. Holland):

"All Salerne's Schoole thus write to England's King,
And for man's health, these fit advices bring.
Shun busie cares, rash angers, which displease;
Light supping, little drinke, doe cause great ease.
Rise after meate, sleepe not at after-noone,
Urine, and Nature's need, expell them soone.
Long shalt thou live, if all these well be done."

"Great suppers put the stomacke to great paine,
Sup lightly, if good rest you meane to gaine."

"Peares, Apples, Peaches, Cheese, and powdred meate,
Venison, Hare, Goate's flesh, and Beefe to eate.
All these breed Melancholy, corrupt the blood,
Therefore not feeding on them, I hold good."

"Your new layd Egs, briske, cheerefull coloured wine,
And good fat broath, in Physicke we define
To be so wholesome, that their puritie
Doth nourish Nature very soveraignly."

"Dwell where the ayre is cleare, sweet, wholesome, bright,
Infected with no fumes, that hurt the spright:
For sweetest Ayres doe Nature most delight."

"If overmuch wine hath thy braine offended,
Drinke earely the next morning, and its mended."

"Young Swallowes that are blind, and lacke their sight,
The damme (by *Celendine*) doth give them light,
Therefore (by *Plénie*) we may boldly say,
Celendine for the sight is good alway."

"Long fasting, vomiting and sudden feare,
Are hurtfull to the organ of the Eare.
Blowes, falles, and Drunkennes are even as ill,
And is so colde, believe me if you will.
Such as would noyses in the Eare prevent,
To shun all these, think it good document."

"To know these Rheumes, this is an observation,
If to the Breast they flow in exaltation.
Th' are call'd Catharre. But running through the Nose,
It's call'd Corisa: others say the Pose.
When by the necke it doth it selfe convey,
They tearme it *Branchus*, as Physitians say."

"The Bones, the Teeth, and Veynes that are in Man,
The Author here doth number, as he can.
Two hundred nineteene Bones agree some men,
Two hundred forty eight, saith *Avicen*,
Numbring the Teeth, some, two and thirty hold,
Yet foure of them by others are controll'd.
Because some lack those Teeth stand last behinde
In child-hood. Others, till their greatest age they find,
The Grinders, and Duales, Quadrupli,
And them above, beneath called *Canini*,
That grinde, that cut, and hardest things doe breake,
And those call'd *Sensus*, Nature these bespeake
To grinde man's food. The veynes in Man wee count,
Three hundred sixtie five, which few surmount."

"Four virtues in the Fennell are allow'd.
It quailles the Ague, when it growes too proud.
Poyson it soon expels, the stomacke cleareth,
Sharpens the sight, and comfortably cleaneth."

"Foure humours in man's body alwayes are,
Bloud, Choller, Flegme, Melancholy. And compare
These, unto those foure severall Elements,
Whereof they are continuall Presidents.
To Earth, Melancholly; to Water, Flegme,
The Ayre, to Bloud; Choller, to fire extreame."

SELECTION.

EXTRACT OF CLINICAL REPORT

OF A FEW CASES OF MINOR SURGERY TREATED WITH CAMPHO-PHÉNIQUE.

By L. A. TURNBULL, M. D.

CASE I. *Burn of First Degree.*—E. C., male, aged 42, was quite severely burned about the face and hands by the explosion of a gasoline stove. The burned surface was bathed with pure campho-phénique, and dressed with heavy wadding of cotton. Analgesia was induced in a few minutes, and the patient made a comfortable recovery.

CASE II. *Burn of First Degree.*—Miss R., an actress, while trying to light a cigarette, dropped a match on her canton flannel wrapper, which was almost immediately in a blaze. She was quite severely burned about the face and hands; campho-phénique pure was applied. Analgesia was perfect in a few minutes, and no blisters formed.

CASE III. *Burns of Second and Third Degree.*—M. S., a strong boy, age 14, poured coal oil in the stove, and his clothes caught fire from the ensuing explosion. From his heels to his knees on the posterior aspect of the leg and to the lateral lines, the entire cuticle came off with the burned clothes; the palmar surface of both hands and the lower third of the forearm were entirely denuded. The chest and abdomen, from the umbilicus to the clavicles, and laterally to the axillary lines, were covered with large blisters and, in places, denuded. The face and ears were badly burned, but the anterior aspect of the neck, from the clavicles to chin, had suffered most; the whole depth of the skin in these situations being entirely charred. The boy's condition was critical, radiation of heat from such extensively denuded areas was rapid, and the shock was profound. The whole burned surface was at once saturated with pure campho-phénique, and covered with a heavy dressing of absorbent cotton and bandages. A hypodermic injection of one-fourth grain of morphine sulphate was given; the patient seemed to rest comfortably, considering the circumstances, and did not complain of much pain. The dressings were changed every third day, and the boy, somewhat to my surprise, I must admit, made a good recovery. The neck, which seems to suffer most in nearly all cases of burns from explosions, etc., caused much trouble, and it was nearly six

months before the wound could be healed, notwithstanding skin grafting, etc.

CASE IV. *Lacerated Wound of Knee.*—Mrs. K., age 44, a very stout woman, weighing, perhaps, 230 or 240 pounds, attempted to board a cable car while it was in motion, and was thrown upon the granite street, striking on her right knee. The great weight of the woman, together with the rough surface of the granite, made a very ugly lacerated wound. The cell tissues, down to the ligaments of the joint, were mashed through and separated, the flaps falling back fully exposed the joint from four to five inches above and below the articulations, and turned both lateral lines.

Added to this, the dirt of the street was ground into the wound. These facts, together with the great excess of adipose tissue, did not make a very promising prospect for union by first intention. The parts were thoroughly washed with warm water, and literally saturated with campho-phénique, and carefully sutured with deep and superficial sutures, without drainage. Great care was taken to make apposition perfect. The whole was covered with cotton saturated with campho-phénique, and a splint and bandage applied. I expected pus, but when the dressing was removed the *line of apposition was not even moist*. On the fourth day, thinking that there *must* be pus in the wound which could not escape, I cut two of the stitches; but the wound was perfectly clean, and healed by first intention.

Remarks.—The neighborhood of my down-town office is one that is frequently disturbed by brawls, and the number of cases similar to those above reported which I have treated in the last seven years is quite large. I report these because I feel certain that, for this class of work, there is *no preparation equal to campho-phénique*, and this opinion is based upon its almost exclusive use during the time stated.

Campho-phénique, while it is fifty per cent. carbolic acid, is entirely unirritating, a good analgesic, controls capillary oozing very promptly, and, above all, there is no danger of the preparation being absorbed, and thus causing carbolic acid poisoning. This is the great danger of even weak, watery solutions of carbolic acid. When the surface to which it is applied is at all extensive, there is always danger of absorption, especially in patients having an idiosyncrasy.

This objection does not apply to a very strong solution, or to pure acid, which form an insoluble albuminate when applied to the tissues. This action is to some extent, however, cauterizing, and this is not to be desired. This objectionable feature is not met with in campho-phénique.

I have seen many formulæ for extemporaneous mixtures of camphor and carbolic acid highly extolled, and have also used Bartholoni's solution (of the pharmacopœia) and a host of preparations, put up by various druggists and individuals. Some of them answer very well in an emergency, but they all have objectionable features, and I have found none so reliable, uniform, unirritating, and so absolutely devoid of danger of absorption, as campho-phénique. I have also used, in some cases, with good results, the campho-phénique powder, recently introduced, but have not employed it sufficiently often to speak of it with any certainty. I suppose that with this, as with all other antiseptics, in fact, with all drugs, the first requirement of success is that the physician applying it must be fully acquainted with its composition, uses, mode of application, and range of usefulness.—*Medical Summary.*

Phenocoll Hydrochloride in an Epidemic of Influenza.—In an epidemic of influenza in the Dosolo and Corregioverde districts of Italy, Dr. G. Villani employed phenocoll hydrochloride exclusively for the cure of some 400 patients. Already acquainted with the value of quinine, phenacetin, salicylate of soda and antipyrine, Dr. Villani was led to employ phenocoll owing to the reputation it had already obtained in Italy for the treatment of malaria, with the result that he continued to prescribe phenocoll hydrochloride for influenza in preference to the other antipyretics.

Dr. Villani came to the following conclusions:

1. Phenocoll hydrochloride exerts a powerful antifebrile action for a period varying between three and four to six hours.
2. It is a useful antiseptic.
3. It is a useful antipyretic and analgesic against neuralgic symptoms.
4. It is easy of administration not only to adults but also to children, the slight brackish taste of the solution being easily covered by a corrective.
5. The system does not become accustomed to the drug and require larger doses.
6. Its administration does not cause nausea, vomiting, collapse or any other disturbance.
7. The reduction of temperature is regular and continuous, being accompanied by a slight perspiration, but rarely by copious sweating.—*Rassegna Medica*, 1896, No. 14.

Etiology of Graves' Disease.—Dr. R. G. Curtin, in *International Clinics* (Vol. IV., Series VI., p. 78, 1897), after discussing the above subject, concludes:

1. Graves' disease is hereditary.
2. The marriage of those having such an inheritance should be discouraged.
3. A person who is known to have the inheritance should reside at an elevation of more than five hundred feet.
4. They should avoid great excitement or any highly exciting occupation.
5. They should not reside in a limestone region.
6. They should not reside in a malarial district.
7. It would be wiser not to select a home in a locality where the disease is common, no matter where the locality may be.
8. They should be careful to avoid all those things that are likely to produce anæmia.
9. They should avoid excessive study, any prolonged mental or sexual strain, or anything which can bring on a neurasthenic condition.

Is Exophoria Curable Without Operation?—Campbell (*The Phys. and Surg.*) says, in the correction of the defect known as exophoria many procedures have been employed as follows:

1. Correction of errors of refraction.
2. General systemic treatment of a tonic, hygienic, alterative, or specific nature.
3. Surgical procedures which consist either in tenotomies (partial or complete) of the external recti, or advancement of the internal recti.

4. What might be called the gymnastic correction of the defect. Each case has to be studied by itself, and one of the above rules applied to its cure.

NEW PUBLICATIONS BY MR. SAUNDERS.

An American Text-Book of Diseases of the Eye, Ear, Nose, and Throat.—Edited by G. E. De Schweinitz, M. D., Professor of Ophthalmology in the Jefferson Medical College, and B. Alexander Randall, M. D., Professor of Diseases of the Ear in the University of Pennsylvania and in the Philadelphia Polyclinic.

MacDonald's Surgical Diagnosis and Treatment.—Surgical Diagnosis and Treatment. By J. W. MacDonald, M. D., Graduate of Medicine of the University of Edinburgh; Licentiate of the Royal College of Surgeons, Edinburgh; Professor of the Practice of Surgery and of Clinical Surgery, Minneapolis College of Physicians and Surgeons.

Anders' Theory and Practice of Medicine.—A Text-Book of the Theory and Practice of Medicine. By James M. Anders, M. D., Ph. D., LL. D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia.

Senn's Genito-Urinary Tuberculosis.—Tuberculosis of the Genito-Urinary Apparatus, Male and Female. By Nicholas Senn, M. D., Ph. D., LL. D., Professor of the Practice of Surgery and of Clinical Surgery, Rush Medical College, Chicago.

Penrose's Gynecology.—A Text-Book of Gynecology. By Charles B. Penrose, M. D., Professor of Gynecology, University of Pennsylvania.

Hirst's Obstetrics.—A Text-Book of Obstetrics. By Barton Cooke Hirst, M. D., Professor of Obstetrics, University of Pennsylvania.

Moore's Orthopedic Surgery.—A Manual of Orthopedic Surgery. By James E. Moore, M. D., Professor of Orthopedics and Adjunct Professor of Clinical Surgery, University of Minnesota, College of Medicine and Surgery.

Heisler's Embryology.—A Text-Book of Embryology. By John C. Heisler, M. D., Prosector to the Professor of Anatomy, Medical Department of the University of Pennsylvania.

Mallory and Wright's Pathological Technique.—Pathological Technique. By Frank B. Mallory, A. M., M. D., Assistant Professor of Pathology, Harvard Medical School; Assistant Pathologist to the Boston City Hospital; and James H. Wright, A. M., M. D., Instructor in Pathology, Harvard Medical School; Pathologist to the Massachusetts General Hospital.

New Volume in Saunders' Aid Series.—Sutton and Giles' Diseases of Women. Diseases of Women. By J. Bland Sutton, F. R. C. S., Asst. Surgeon to Middlesex Hospital, and Surgeon to Chelsea Hospital, London; and Arthur E. Giles, M. D., B. Sc., Lond., F. R. C. S., Edin., Asst. Surgeon, Chelsea Hospital, London.

REPORT OF THE FORTIETH ANNUAL MEETING
OF THE
Missouri State Medical Association,
HELD AT
Century Theater Building, St. Louis, May 18, 19 and 20, 1897.

Association was called to order by the President, Dr. J. H. Duncan, of St. Louis.

Invocation by Rev. Dr. N. Luccock, pastor of the Union M. E. Church.

Address of Welcome to the City by Hon. Henry Ziegenhein, Mayor of St. Louis. Mayor Ziegenhein cordially welcomed the profession to the city, asking them to feel at home, and on their return to their homes to feel that St. Louis is the home for doctors as well as the city for conventions. Though he had had no use for doctors professionally for over fifty years, that did not prove they were not useful. He hoped that when they departed they would feel that St. Louis and Missouri are strictly in it.

Address of Welcome on Behalf of Physicians of St. Louis by Dr. E. H. Gregory, Ex-President of the Association. Dr. Gregory said: The medical profession of St. Louis with outstretched arms receives you. Our welcome is not an empty sentiment. He said: I have watched the progress of this society for nearly half a century. The first President, Dr. W. G. Thomas, was my teacher. All doctors should have high regard for the sacredness of professional honor. My honor is my life; take from me my honor and I die with it. There is no new revelation in medicine; simply a change in direction. The physician of the past was concerned about the disease, but not much about the cause; the physician of the present day is concerned about the cause, and not so much about the disease. The physician of the past studied the nature of disease; the physician of to-day studies the etiology. The study of cause of disease of the present day has done more to bring medicine up to the high standing that it now has than anything done in the past. He then spoke of the work done by Virchow and Pasteur in tracing the cause of different diseases to the bacilli. In the past there was as much interest taken and as much labor performed in the study of medicine as at the present time, but, unfortunately, energies were misdirected; now all energy is utilized. We have learned of the chemical action regarding vitality and life, and we recognize conditions.

Response on Behalf of the Association to the Welcome of the Mayor and Dr. Gregory by Dr. A. B. Miller, Ex-President, Macon. Dr. Miller said he "deemed it an honor as well as a privilege to say that, in behalf of the Missouri State Medical Association, we accept the greetings extended to us by the Mayor of the city and Ex-President Gregory." He said: The object of this convention is to meet and compare notes, get new ideas,

and give each other the benefit of past experiences and discoveries, so that we may be more efficient at the bedside." He spoke of the advances made in medicine. Not many years ago the insane were held in prisons, but now, through the influence of their friends, they are placed in nice homes built especially for them. The world appreciates these efforts made by the profession on behalf of their unfortunate friends. He then briefly referred to the work done in the past by the Association, and to the very valuable aid received from the city of St. Louis.

The chairmen of the different committees gave their reports, which were accepted.

REPORT OF THE COMMITTEE ON EDUCATION.

(a) *Methods of Teaching; The Value of Clinics and Laboratory Work.*—

G. R. HIGHSMITH, Chairman, Carrollton.

Dr. Highsmith said: There is no danger of raising the standard too high. Things have changed since you and I studied medicine. Men who are now in the front rank could not enter under the present conditions. Things then considered nonsense are now most scientific. We have many, too many, schools in the United States, and very many, too many, in the State of Missouri. The laboratory and text-books are now essential in the study of medicine, and old methods are being abandoned; yet the didactic lecture will always have its place in the medical schools. Medical schools must have endowments, and if they cannot have more money they cannot do good work. If they cannot get the endowment from the State or from private subscription, it would be better to seek union with our universities. The State should give as much money for the benefit of man as for the purpose of raising cattle. He then gave statistics showing the increase in the endowment funds of theological over that of medical schools. Practical work and thorough instruction in bacteriology should be required in every school, and a knowledge of this essential branch of medicine should be a part of the education of every graduate in medicine; and no man should be considered competent to practice without this knowledge. In order to teach bacteriology we must have well-equipped laboratories. It is impossible to make an efficient bacteriologist without the aid of the microscope. This country is not in need of more men possessing diplomas—it has many thousands more than it needs. It should have several thousand more good medical schools. The progress in medicine up to the present day has been enormous, and the future is bright for medical advancement.

(b) *A State License to Practice Medicine; Is It Desirable?*—J. F.

BINNEY, Kansas City.

Dr. Binney said: The power of granting diplomas to medical students should be taken from the medical colleges, and in their stead a State examining board should be appointed. Said board should be composed of the following members: one appointed by the Governor, one by the State Medical Association, one by the State Homœopathic Association, and two by the deans of the various medical colleges; and that only those possessing a license issued by this board should be allowed to practice medicine. He said there should be more stringent rules regarding the

capability of the student. Such a board would not interfere with the colleges properly equipped, but those not well equipped would have to close. There is now nothing to prevent the too sympathetic teacher from conferring the degree of M. D. on those not qualified to practice. All things being equal, men accustomed to teaching are more expert in drawing out of pupils that which they really do not know; therefore the teachers should not examine their students when the degree of M. D. is to be conferred.

(c) *The Value of Certain Preliminaries to the Medical Student.*—W. H. EVANS, Sedalia.

Dr. Evans was not able to meet with the Association, but sent a request that his paper be read by Dr. Highsmith. The request was granted by a unanimous vote of the Association.

Dr. Evans stated that the man with no education is placed at a great disadvantage when studying medicine, taking the same course along with one well trained and well educated. A man without a thorough literary education has no business in the practice of medicine. He spoke of the hard struggle he had to get along, going to school in the winter and working on the farm in summer. A man must know and practice medicine and surgery as they are to-day, or else give up the struggle. He said: I am glad that the requirements within the last two years have been more exacting; yet there is still room for improvement. I have been discouraging young men who are poor and have no education from studying medicine, for it is a life-time work. Doctors are not born—they are made. We must be more practical. The remedy for the present condition of affairs lies in giving the jurisdiction to the State.

DISCUSSION OF THE PAPERS ON MEDICAL EDUCATION.

Dr. Lester Hall, of Kansas City, said, in referring to the paper on Laboratory Work: To the majority of general practitioners it is impossible to distinguish the presence of the Klebs-Loeffler bacillus, the cause of diphtheria; and the physician who waits for such a bacteriological demonstration before treatment will, in a vast majority of cases, sign a death certificate. The man who cannot diagnose from the appearance of the membrane without the presence of the bacilli being demonstrated, is certainly lacking in a knowledge he should possess. It is very important to discover the bacillus, but it will not do to trust to such slow measures before beginning treatment. It can be diagnosed from clinical symptoms. He said: I think the suggestions made by Dr. Binney a step in the right direction. As a friend of Dr. Evans, I must protest against the self-abnegation in the first part of his paper. Some of our best physicians are those who have struggled against the disadvantages of early history. I do not think a man like Dr. Evans should be debarred from the practice of medicine because he did not have the advantages that the student of to-day enjoys.

Dr. F. J. Lutz, of St. Louis, said: The State Board of Health, acting in conjunction with this great Association, has done much toward placing the practice of medicine on the high plane which it now has, and the Association of the regulars are anxious to give a good account of their steward-

ship. I take it from what Dr. Hall says, that he is criticising the methods of instruction in medicine generally. The writer presented the methods of teaching that are in vogue to-day. The old-fashioned method of didactic lectures has been relegated to the past. The student can read the pathology and treatment of a disease in a text-book better than any professor can present it. The place to diagnose pneumonia and tuberculosis is at the bedside and in the laboratory, and he who is not competent to make a bacteriological examination of the excreta and membranes from the throat of a patient, which can be done in something more than fifteen minutes, is not abreast of the times and does not realize his responsibility to the patient, and is not as familiar with modern researches as every physician should be. He agreed with Dr. Binney's method of electing a board to grant a license to practice medicine.

Dr. MacAlister, of Columbia, said: The State Board of Health has begun a good work. They took every step cautiously and judiciously, but the Supreme Court of Missouri steps in and robs the board of the power they supposed they possessed, and to-day this board has no power by which it can regulate the practice of medicine. We stand where we receive the offscourings of every State, if they have a mind to come to us. To say that things are to-day the same as when I left college, would be saying medicine has made no progress. We have made great progress. Medicine was not considered a science until the last ten years.

Dr. J. N. Matthews said: I fully agree with thoughts presented in the paper on Preliminary Education. As a Missourian, I ask what chances and what prospects have we of ever reaching the high ideal suggested by Dr. Binney? None of us will ever live to see that day, and especially is it far off since we cannot hold up the hands of the officers provided by the State. We are divided among ourselves as to the support we shall give the board. The board has endeavored to elevate the standard required from those who enter our colleges. This movement is not fought by the public—the objectors are in our own profession. We should not oppose, but uphold. If we are not willing to accept the help offered us by the board, it is unnecessary for us to discuss this unpractical question.

*Dr. A. B. Miller, of Macon, said: I am in sympathy with all said on the necessity of a good preliminary education. It is very important to a young person now entering the medical profession. In my opinion, the colleges are as good as the profession demands they shall be. The schools will have to come up to the requirements, and it devolves on us and every physician of the State to have a high standard, high requirements and high ideals. The men who compose the faculties of colleges desire the highest possible results. I am not in favor of accepting students who have not a good education.

Dr. I. N. Love, St. Louis, said: It behooves all of us to endorse the late action of the State Board of Health. It is a start in the right direction. The mistake is that from the beginning and all along the line we have not had laws that would hold. We could not depend on our legislative bodies. The legislators we now have will not co-operate with us. Let us lay down our arms for the time being and let sentiment grow. He said: Let each and every doctor who is anxious to be preceptor, resolve that he will cease

desiring a large class of students and only accept those who are properly qualified, possessing the necessary education for the prosecution of their studies. Let us quietly acquiesce in the powers that be and admit that we now have no place on the map of Missouri, but in the future let us see that the men whom we send to Jefferson City are our friends.

Dr. R. T. Sloan, of Kansas City, said: I consider this a good time to discuss the question of having a State board grant a license to practice medicine. The medical colleges of this State are better than the profession demands they shall be. The faculties desire a better class of students and better material to work on. The State Board of Health, instead of giving the cool bath indicated, gave ice water. They did not know what was required. Preliminary education is a good thing, and in the future more will be required from those entering the profession. He said he did not believe any State board would be able to give satisfaction to those connected with medical schools. The ideas advanced in the paper on a State license to practice medicine are along the right line.

Dr. Lutz, having been granted permission to reply to Dr. Sloan, said: I listened with interest to Dr. Sloan and was surprised at such remarks coming from him. The standard made by the State board was so low we felt we were not elevated. This was not done suddenly, but has covered a long period. They first required a diploma or first grade certificate. The examinations were made by medical colleges and were farces. Medical colleges are not run for the benefit of the public health, but for the benefit of the professor; and the easier it is to graduate students, the better the professors like it. He said: I would not care if the board was composed of men of the college profession. Ought not question the purity of a man's motives because he is connected with a medical college. The requirements are not too high; the question is, Are the colleges living up to the requirements?

Dr. Highsmith was given ten minutes for closing remarks. He then said: I have nothing to say except to thank the gentlemen who criticised my paper, favorably or unfavorably.

Dr. Binney arose and said ditto to Dr. Highsmith.

On motion, Association was adjourned.

[TO BE CONTINUED.]

Spurious Coca Wines.—The *British Medical Journal*, in its issue for January 23d, and again in that for February 6th, speaks of the dangers that attend the popular use of so-called coca wine—that is, some kind of wine in which a salt of cocaine is dissolved. For the most part, the wine is of poor quality, but sweetened and highly fortified with rectified spirit. The amount of cocaine contained in many of these products is variable, too, and in prescribing them one really does not know what doses of that drug he is ordering. Moreover, the contention seems reasonable that the tonic and stimulant virtues of a real wine of coca—such, for example, as the well-known Vin Mariani—do not depend altogether upon the cocaine contained in it.—*New York Medical Journal*, March 20, 1897.

PUBLISHER'S DESK.

Amenorrhœa, by which we understand a scanty flow, as well as none at all, cannot be treated as an independent affection. It is only a symptom and always due either to a local or constitutional defect. Pregnancy and lactation being excluded, the first step for a successful treatment is to discover the cause. When due to mechanical obstruction of the uterine canal, vagina or vulva, surgical treatment in the form of dilatation, incision, removal of tumors, etc., is indicated. Amenorrhœa frequently follows grave constitutional diseases, leaving the entire system in a weak and prostrated condition, but mostly accompanies anæmia or chlorosis of young women. Here the treatment is plain: general nutrition, fresh air, moderate exercise, and such tonics which will not only restore the strength of the system but improve the condition of the blood. We believe among the vast number of tonics Henry's three chlorides to be the best. A glance at the formula will suffice to satisfy any thinking physician of its special merits in the treatment of amenorrhœa due to constitutional defects.

BIRMINGHAM, ALA., June 12, 1897.

RESINOL CHEMICAL CO., Baltimore, Md.

Gentlemen:

I wish to say a few words of highly deserved praise in reference to your wonderful preparation, unguentum resinol. I have had the most flattering success with it in my practice in the treatment of pruritus ani, itching piles, and also in allaying the intense itching and burning of eczema. I have found it superior to any preparation of its kind that I have ever used, and I think it stands without a peer as an antipruritic and sedative. I could relate many interesting cases in which I have used unguentum resinol. I trust that all of my professional brethren will use this valuable preparation whenever it is indicated.

Yours most respectfully,

A. L. SCOTT, M. D., Ph. G.

Pain and Its Therapeusis.—Dr. S. V. Clevenger, after pointing out the disadvantages of various analgesic drugs, states that lactophenin is destined to supersede largely the entire array of analgesics proper, owing to its non-toxic peculiarities and the feeling of comfort described by many physicians as following its use. It affords the best results with the least ill effects. Its range of incompatibility is less than other synthetic compounds, and it may be combined with caffeine, quinine and salicylic acid. The minimum dose of 5 to 10 grains may be increased until a maximum of 45 grains has been reached. It is but slightly soluble in water, although acting promptly, so that it can be given dry, and be washed down with a drink of water. A dose of 15 grains usually acts as a feeble hypnotic. There are no untoward symptoms following its use, and, contrary to the experience with some synthetic drugs, the pulse becomes fuller and stronger under its use. The range of application is extensive, and the testimony of the author is in

corroboration of the findings of other physicians as to its superior analgesic effects, its safety and promptness of action.—R. W. Wilcox, M. D., in *American Journal of the Medical Sciences*, May, 1897, quoting from *Journal of the American Medical Association*, 1897, No. 5.

A Valuable Hypnotic in Pneumonia.—The necessity of overcoming the insomnia attending certain cases of pneumonia ought to be evident to every physician. Probably nothing known to the profession can alleviate the distressing symptom of sleeplessness so satisfactorily and with so few after-effects as bromidia. By the use of this reliable preparation we can obviate the effects of losing sleep and at the same time feel that the heart's action is unimpaired, a dire calamity in a pneumonic process.—*Vermont Medical Monthly*, February, 1897.

Imperial Granum.—This standard prepared food for invalids and children has won the enviable distinction of having successfully stood the crucial test of years of actual clinical experience in private practice, sanitariums and hospitals, while numerous competing preparations have appeared and disappeared—often so completely that even their names are forgotten. The imperial granum, however, enjoys so universally the confidence of physicians that its merits are beyond dispute. Moreover, the decision of its manufacturers not to publicly advertise it has secured for it the endorsement of even the most ethical members of the medical profession, who dislike to prescribe any article advertised broadcast to the people and profession alike. Physicians can obtain sample packages free, charges prepaid, on application to the Imperial Granum Co., New Haven, Ct., or John Carle & Sons, New York City.

The Treatment of Chronic Rheumatism.—One of my patients, whom I had treated for some time for chronic rheumatism with but indifferent results, as is usual in such cases, asked me to make a special effort to find some remedy that would not only give him temporary relief, but which would cure him. I had given him from time to time the various coal-tar products, salicylates, single and combined with colchicum, mrocrotyn, iodide of potass, etc. Phytoline was recommended to me and I concluded to give it a trial. The result was far beyond my most sanguine expectations, and a happy one, indeed. Phytoline "just touched the spot." In the course of six weeks my patient was entirely free from rheumatism, and has been well ever since.
E. C. BECK, M. D.

Chronic Gout.—Chronic gout, while not a fatal disease *per se*, is a dangerous affection on account of atheroma and involvement of the kidneys, depending as it is upon an increase of urate of soda in the blood depositing itself in certain joints and internal organs. These deposits consists of sodium urate, sodium chloride and calcium phosphate. The entire arterial system is apt to become atheromatous, causing hypertrophy of the left ventricle of the heart.

The treatment therefore is plain. Active exercise, bowels must be kept open daily. Hot baths are of service. Alcoholics should be interdicted. Among drugs, besides alkalines, colchicum and iodine are the best; salicylate of sodium is very useful. A preparation containing colchicine, decandrine, solanine, iodic acid and sodium salicylate in a cordial, known to the profession as Henry's tri-iodides, meets not only all indications, but has clinically proved itself the most useful combination ever offered.

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., JULY, 1897.

No. 7.

ORIGINAL ARTICLES.

THE MEDICO-LEGAL STATUS OF THE SURGEON WITH PATIENTS UNDER HIS TREATMENT FOR FRACTURES.*

By W. F. MITCHELL, M. D., of Lancaster, Mo.

THERE is, perhaps, no more frequent injury than fractures, affecting indiscriminately all classes of society. The surgeon of the city, the humblest practitioner in the small hamlet in the country as well, frequently meets with such injuries. So frequent is this class of injuries, and the attending surgeons of such varied ability, there is no wonder we meet with so many crooked limbs, and see so many cases of alleged malpractice suits filed upon the records of our courts. While we do not suppose for a moment that all the cases of alleged damages for deformed limbs are the fault of the attending surgeon, yet it must be admitted that in many cases if they had been accurately diagnosed and treated properly from the beginning, they would have had sound and useful limbs instead of deformed and almost useless extremities. I don't want to be understood that it is possible every time for the surgeon to be able at the outset of the injury to make a clear diagnosis; nor do I mean to say that the surgeon, I care not how able he may be, will always have a good result. There may

* Read before the Northeastern Missouri Medical Society, at Memphis, Missouri, April 6, 1897.

exist some dyscrasia in the individual that will materially affect the callus, as syphilis, etc. The patient may be refractory and disobedient, which, of course, will lead to bad results.

Aside from the faulty constitution of the patient there may exist the following causes of vicious union on the part of the surgeon: *First*, gross ignorance on the part of the attendant; *second*, gross negligence or carelessness. This second cause is more frequent than any other. The late Professor Samuel D. Gross, the Nestor of surgeons in his time, said: "If I were called upon to testify what branch of surgery I regard as the most trying and difficult to practice successfully and creditably, I should unhesitatingly assert that it was that which relates to the present subject, and I am quite sure that every enlightened practitioner would concur with me in the justice of this opinion."

The statement of this eminent surgeon one-third of a century ago is yet true in every particular now as it was then. He further states: "Experience satisfies me that few practitioners know how to examine a broken limb. They take hold of it as if they were afraid of causing suffering, and the result therefore is often most disastrous."

In speaking of fractures of the extremities of long bones: "Under such circumstances, therefore, he must not content himself with one or two trifling explorations. He must handle the parts again and again until he has thoroughly established the diagnosis."

With children, especially, I have had to resort to the use of an anæsthetic in order to be able to make a clear diagnosis. The first place is to ascertain what is the matter. Be sure you are right then go ahead.

If there is any time in the history of a surgeon when he should have a dignified bearing and knowledge of the law, it is when he is superintending the reduction of a fracture. He should not for a moment forget his responsibility to his patient or his duty to himself. His order must be explicit, plain, and given with a firmness not to be misinterpreted by any one. He should leave his directions plainly written and make a copy, date it and file it away for future reference. In no case fail to return in a few days and examine the limb and see how it is progressing. And it is well enough to examine it again while the callus is yet soft, and if there be any deformity it can be remedied without much difficulty, always having in view that notwithstanding our vigilance we may not always have a successful case; yet if we give close attention to the case we will be less likely to get a damage suit on our hands for malpractice, which, even were we to be successful in defeating, the loss of time, the annoyance and the attorney's fees would very materially injure one financially. By being careful and painstaking in the examination of the broken limb, and having a clear diagnosis, one's mind is placed at ease, and we had better be slow and deliberate in making up our diagnosis than to come to a hasty conclusion, which may mean to us in the future much serious reflection.

Before dressing the broken limb, whether it be a single or compound fracture, it should be aseptized. I have seen some of the direst results in compound fractures by the neglect of this important subject. Even if the skin is not broken, though more or less bruised, it is no less a duty to free the surface of the fractured member of the germs that are on the surface. The staphylococci may penetrate the bruised skin over the broken bone

and induce suppuration in the wound. Let it not be forgotten that the surgeon who is ignorant of the use of antiseptics, and neglects to asepticize wounds, or through neglect fails to look after this important duty, will be held liable in the court; and if a life is sacrificed by this negligence, a prosecution of the surgeon for manslaughter may follow.

A young man once inquired of the late Professor Moses Gunn the way to become a good surgeon. He was answered by the doctor: "Study anatomy well." Nothing is more important and enables the surgeon to proceed in the examination with the satisfaction that is enjoyed by the mariner who knows the use of the compass; he is never lost, though the sea be ever so deep or wide. A comparison with the opposite limb and a measurement should never be neglected. Sometimes we find a disparity in the length of the two limbs from natural causes. The law defines the necessary qualifications that the surgeon should possess. I quote from Hamilton's "Legal Medicine," Volume I., pages 605-6: "Thus it has been said that the degree of skill and knowledge required in any locality must be that ordinarily possessed by physicians in the like general neighborhood and lines of practice, having regards to the advanced state of the profession at the time; it being manifestly unfair to exact the same degree of attainment, especially in surgical skill, of a practitioner in a sparsely settled country, devoid of libraries and hospitals, as may be properly expected of one practicing in a great city. But it was held erroneous and misleading to charge that a defendant was only bound to employ the degree of skill ordinarily exercised in the locality wherein he practiced, for it might happen that there were none but quacks practicing in the vicinity; and proper to charge that he should have the average skill possessed by the profession as a body, having regard to the advanced state of the profession at the time of treatment, or ordinarily possessed by physicians of that period. So it has been said that the true standard by which to determine the skill to be expected of a physician is not that of the thoroughly, moderately well educated, but of the average. The law recognizes both that a small matter if worth doing is worth doing well, and that in a grave cause one can only do his best, and therefore it has been held error to charge that the degree of care and skill required of a surgeon should be proportionate to the severity of the injury."

It not infrequently happens where there should be the least difficulty in securing a favorable result that the surgeon meets with a surprise—a crooked limb. His ignorance or gross carelessness is alleged, and a suit for malpractice follows, as did a case a few years since in a neighboring county in this State. A young man sustained a fracture of the tibia at the lower third. Two physicians were called to reduce the fracture. They were partners. It was put in temporary splints. The next day Dr. C. put on a plaster-paris bandage. He said the limb was not contused or inflamed or swollen much. Plaintiff stated the doctor said the bandage could be taken off in three weeks, told him to get on crutches. The doctor did not come back any more. In the meanwhile he heard every few days from the patient, who was represented as resting well. The patient's father told the doctor, he says, when the three weeks were up, what he said about taking off the plaster cast. He said it could be taken off any time, went home, told the patient, who the next day cut off a portion around his heel,

and the following day he removed the entire splint. Still went on crutches, and in ten days went to town, rode on horse-back, saw Dr. C. The doctor asked him why he did not walk on his foot. He told him he did not feel stout enough. The doctor examined the limb and said it was all right. Plaintiff called several times during the summer and fall. The doctor did not admit the limb was not right till about Christmas.

Doctor C. denied giving the patient the liberty to remove the splint. The second or third time the patient visited his office he complained that his leg ached. He examined it, told him that he had walked on it too soon. Doctor said that patient admitted he felt something give way when he bore his weight on the limb just to try it. This was proven by a disinterested witness who said he was in the doctor's office twice when the patient was there. Doctor C. offered to reapply the plaster cast which was refused. Medical experts testified that the limb was not much crooked, nor was the toe much everted, and there was but little shortening of the limb, and that Dr. C. was a well-qualified surgeon. The jury found for the plaintiff in the sum of two thousand dollars. The case was sent up to the Kansas City Court of Appeals, and remanded back to Macon county on account of errors in the instructions; change of venue was taken to Schuyler county, and it was tried there with a verdict for the plaintiff of fifteen hundred dollars, which was sustained by the Kansas City Court of Appeals. The physician who was the senior partner, who had nothing to do with the case after the temporary dressing was put on, had to pay the entire amount with the costs. Such is the law. A physician should understand that partners are equally liable, and if only one of them has any money he will settle the damage.

Legislative bodies seem to legalize and approve what appears to us as nothing but the commonest sort of empiricism. Men who occupy high places in State and wealth will patronize and even laud some of the grossest frauds as quite efficient in the cure of disease. Judges on the bench will assent to treatment by some of the most frivolous pathies. But when it comes to having their anatomy broken up, they want a competent person to put it together, and they require in terms not to be misunderstood that they want the surgeon who has the qualifications and is acquainted with the latest methods of treatment, and if they have their choice, they would prefer an eminent to the average surgeon. They want it done right. The honest laborer in the field of science has no reason to become discouraged because he meets all classes of imposters whose only aim is to obtain money or reputation under false pretense. Scientific men cannot afford to stop and quarrel with them, nor can they cease to continue their investigations of the many subjects that pertain to the well-being of our race. Men who are devoting their lives in the search of truth, who are honestly seeking for the true methods of treating diseases and the management of the injured, need not stop for a moment and lay down the scalpel or lay aside the microscope or close the laboratory. Go on in the work. It took centuries to convince the average citizen in what was considered a civilized country that the world was round like a sphere, and still there are some that doubt it. It may take centuries yet to convince the world that unless what purports to be true harmonizes with common sense, is certainly a fraud.

No physician or surgeon who has taken the degree of M. D. can for any time sit down and think he has risen to an eminence where he will never be disturbed. Every physician owes it as a duty to his profession, as well as to himself, that he continue his study and always have a familiar acquaintance with those injuries which so frequently occur as fractures and dislocations, never forgetting the rules of the court that we are liable for gross negligence; if there is a palpable crook in the limb, that the burden of proof will be thrown upon the surgeon to show to the jury that he has discharged his duty.

The regular medical profession, while it has made all the scientific progress that has been accomplished, yet it must be confessed there has been a great rush into its ranks since the late Civil War, many of whom had very little qualification for study, and have no higher idea of professional character than to suppose that it is an easy and rapid way to acquire wealth. It is an imperative duty incumbent upon every regular physician to know exactly what to do and discharge his duty well. While we are not, any of us, infallible, let there be found but little fault in our work, which is the best argument we can give of our ability.

LARYNGISMUS STRIDULUS AND SPASMODIC ASTHMA.

By WESLEY G. BAILEY, M. D., of Pekin, Ills.

Terrors of:—In the minds of the laity few diseases produce the terror that spasmodic croup of the young does to the parents of such patients; and, indeed, when purely spasmodic cases, few ailments provoke so much distress, both to the young or adult sufferer.

Nomenclature:—Laryngismus stridulus, spasmodic croup, pseudo-croup, and spasm of the glottis, are terms variously applied to a spasm of the muscles of the larynx.

Etiology:—* “M. Schier, of Berlin; Lumbau, and Przedborski, adduce cases to illustrate the connection between hysteria and laryngeal spasm.” “Huchard, of Paris, ascribes severe stridulous laryngitis in children to inflammation and spasm of the larynx, the spasm constituting the danger.” Most authorities agree that the chief cause lies in the loss of force of the recurrent laryngeal nerves; *i. e.*, an † “irritation of the terminal filaments of the pneumogastric in the mucous membrane of the larynx, the transmission of this irritation to the pneumogastric nucleus, and its reflection over the motor nerves supplying the laryngeal muscles.” These patients are usually of a nervous temperament, highly impressible of external as well as auto-suggestions. The blood is of an highly acid condition; and if the urine is analyzed there will be found a preponderance of the phosphates.

Diagnosis and Symptoms:—These are almost too well known to need a description. Generally, the patient is or has been perfectly well; just previous to the attack a slight cold may be present; the sudden onset of

*“Annual of Universal Medical Sciences,” 1895, Vol. IV.

† Bartholow’s “Practice of Medicine.”

the disease, together with no previous illness, and a history of exposure to cold, or wet, or an overloading of the stomach, particularly at night, with young children, is usually sufficient to distinguish the case from membranous croup or laryngeal diphtheria; there is more prostration and a decided odor to the breath with the latter disease also.

Pathology:—No genuine pathological condition peculiar to this disease exists; except, perhaps, the acid condition of the blood.

Prognosis:—The prognosis is usually favorable, as one or two nights at most is the greatest length of time the majority of cases run; when a case is not seen early there may be extreme exhaustion, from the prolonged effort to breathe, more particularly inspiratory, and the case may be almost moribund. There are families in which croup is a chronic trouble, any little excitement, as anger, overjoy, a too full stomach, etc., causes an outbreak of (usually) nocturnal spasmodic croup; these patients it becomes necessary to watch constantly, because too frequent attacks may cause chronic laryngitis, and from this generally a case of chronic bronchial or spasmodic asthma supervenes.

Treatment:—In cases not seen until nearly moribund it may be necessary to perform tracheotomy; which should it become necessary to do, no time must be lost or foolishness exhibited; tell the parents what you must do and be expeditious and positive about your statements and motions. From what has been said about the causation, it should be inferred that when your cases are not too young, and during the interregnum between attacks, suggestive therapeutics might play an important role in curing this malady; this is very true, though the writer can mention but one case so treated with any benefit. As heredity plays an important part in the etiology, this should be thought of in future marriages. To treat this disease from a scientific standpoint our key-note is the acid condition of the blood and the nervous temperament; hence, theoretically, a combination containing active antispasmodics, sedatives and alkalines would be *the* thing. Practically, after many years trial and the treatment of several hundred cases, we have found the following combination most highly gratifying (both to patient and physician): Iodide and bromide of potassium, helianthus annuus, ipecacuanha, lobelia, and leonora cardia; this prescription is most elegantly compounded by the Tilden Company, of New Lebanon, New York, and St. Louis, Mo., and is known to the trade as respirazone. As to what success we have had with respirazone, we will cite a few of the most prominent cases.

Spasmodic Asthma:—In treating of spasmodic asthma in an article of this nature, it should be remembered that spasmodic asthma of adults is a spasm of the muscles of the bronchial tubes, and is relatively caused by much the same factors producing spasm of the glottis in the young, hence, treatment carried out on the same plan is usually successful.

CASE 1.—Mrs. A., multipara, aged 44; has had spasmodic asthma for twenty years; has never had permanent relief until lately; patient is of a highly organized nervous temperament, and a microcephalic; has taken everything she could hear of for relief; was over a year under the Buffalo, New York, World's Dispensary treatment, and was finally prevailed upon to take respirazone, and now has no more bad night attacks as long as she faithfully takes the respirazone according to our directions.

CASE 2.—F. W., male, aged 5 years; has an hydrocephalic head, rickets, though not a pronounced case; is continually taking cold, and overloading his stomach; we were called a few months since hastily, at night, to attend him in a bad case of "croup;" child was very sick when first seen; all of my favorite croup remedies gave very little temporary relief, even chloroform and hypodermics of morphia gave no permanent benefit; child was ill for over a week and was thrown into convulsions, so great was the fever and lack of oxygen; we almost despaired of curing him, when we thought of trying respirazone; we were not altogether pleased with the results at first, but after a persistent trial we scored a complete victory upon respirazone alone; child was ill over two weeks, and was the worst case of laryngismus stridulus we ever saw.

We have not cited more cases because they were only of the usual variety, but if any physician who has had cases of either "croup" or spasmodic asthma will faithfully try Tilden's respirazone, we are convinced that he will not be disappointed in using, but will be thankful that (as we have been) some one called his particular attention to this preparation.

FAVUS.

By A. H. OHMANN-DUMESNIL, of St. Louis.

THIS parasitic disease of the skin is also known as tinea favosa, its more common and generally known name among the laity being "honey-comb ring-worm." The disease is not infrequently seen, and yet it is far from being common in this country. This is probably for the same reason that other parasitic diseases are not encountered as often as abroad. The lower classes are more cleanly about their persons and their clothing and not huddled together to the same degree as in Europe, where this class of diseases seem to have extraordinary facilities to thrive and extend from one individual to another. The frequency of favus varies much in different countries and even in different sections of a country. Whilst more cases are seen in densely populated cities, it is equally true that in certain extra-urban localities an entire district will be encountered in which every inhabitant is affected, the cause being principally negligence and the lack of proper care and cleanliness of clothing and person. Taking the records of dermatologists and their statistical tables we find that the disease is frequently seen in Scotland more so than in England, where it is by no means uncommon. It is certainly far from rare in France, and is often observed in Austria. Strange as it may seem, favus is seen with tolerable frequency in Germany, and yet it is looked upon as a sort of curiosity in Berlin. But a few years ago Max Joseph presented a case to the Berlin Medical Society as a sort of rarity, showing the almost total absence of favus in the German capital. In this country it is by no means a rare trouble, although it is very far from being common in its occurrence. No one who has had any considerable medical experience but has seen several cases, and dermatol-

ogists do not class it among the unusual cases. There was a time when favus was quite an important disease in a certain sense of the term, from the fact that it was looked upon as a serious disease, which was incurable. So serious was it looked upon that it was deemed of sufficient importance to exempt a recruit from military service. It was observed that the prevalence of favus increased to a remarkable degree in consequence of this ruling. When the law was repealed favus diminished in frequency to a marked degree and methods were soon found to cure it. Whilst these latter were somewhat drastic they proved quite efficient in not only curing the cases which existed, but in preventing as well the artificial spread of the disease.

Favus is not a disease of human origin any more than ring-worm. The latter is indubitably of equine origin, and researches made by competent authorities have shown that the former originates in the mouse. The mouse transmits the disease to the cat, this animal being susceptible to the parasite. It can be easily understood how a cat may transmit the disease to human beings directly and by way of mediate contagion. As is well known, the cat is always a great pet with children, and these latter in stroking it and playing with it easily acquire the trouble; adults will then become infected by the children, if they be in the same family, although it may be noted that children are much more prone to become so than their elders. It is for this reason that the disease is more frequently seen in children. It must not be forgotten that favus is highly contagious and easily transmissible from one individual by a number of ways. Among these is the indiscriminate use of toilet articles, such as combs and brushes. Next in order is the exchanging of wearing apparel, but more particularly, hats and caps. This latter is a very common habit with young children, and leads not only to the transmission of favus but of other vegetable and of animal parasites. The ease with which favus may be acquired is well illustrated in the report of a case of favus of the hand which was published some years ago in the *Journal of Cutaneous and Venereal Diseases*. A clerk went to clean a drawer among others in a store. He found a mouse's nest with several young mice in it, and from the appearance they presented they were but two or three days old. He proceeded to take out the pieces of paper of which the nest consisted and scraped up all of this with his hand. He cleaned out the drawer and proceeded to clean out others. In a comparatively few days he noticed an eruption on the volar side of his hand, and a dermatologist pronounced the trouble favus. It was quite a simple matter to trace the origin of the trouble, and it was as is given above. Considering the fact of the thickness of the epidermis of the skin on the affected site, the short period of exposure, and the rapidity with which the eruption developed, it is obvious with what ease favus may be acquired. And, when we consider the fact that young mice with tender skins are bred in infected nests, we can easily explain the fact that favus is an endemic disease in this variety of rodents. Again, it is well known that they herd together and any which might have escaped the contagion very rapidly succumb to it and, in their turn, exhibit the disease upon their skins. But it is our purpose to consider favus in the human, and sufficient has been said in regard to it in its occurrence in animals to give a fair idea of the reason of its prevalence in them, and to account for its easy transmissibility to children and adults.

Favus in its inceptive stage should be easily recognized from the peculiar form of the lesions which it presents. These are yellow "godeys" or cups with raised borders bearing a strong resemblance to a watch-glass in form, the so-called "scutula." They are but a sixteenth of an inch in diameter, or thereabouts, and increase rather rapidly in size.



FIG. 1. Favus of the Body.

Before a scutulium appears a reddish macule is observed, and this presents a somewhat fine scaly appearance. It is at this site that a "cup" appears and that a certain amount of itching is experienced. The color of the lesion is a sulphur-yellow at first, but it soon assumes a dirty-yellowish tinge from

the foreign material which adheres to it. It is quite adherent to the skin on account of a certain amount of the horny layer of the skin forming a lap over its edges. When separated it is found to be quite friable, and is, in great part, composed of the vegetable parasite which causes the disease. The distribution of the lesions is discrete at first, but it is not unusual for the scutula to form one mass, simulating a dirty crust and having a tendency to become quite thick and friable. The distribution of the disease is peculiar in one respect. It may be either limited to the scalp or it may occur upon the scalp and body. It is rarely limited to the latter except in special instances. For example, it may be found in infants at the umbilicus alone, but this is rather of exceptional occurrence.



FIG. 2. Favus of the Scalp.

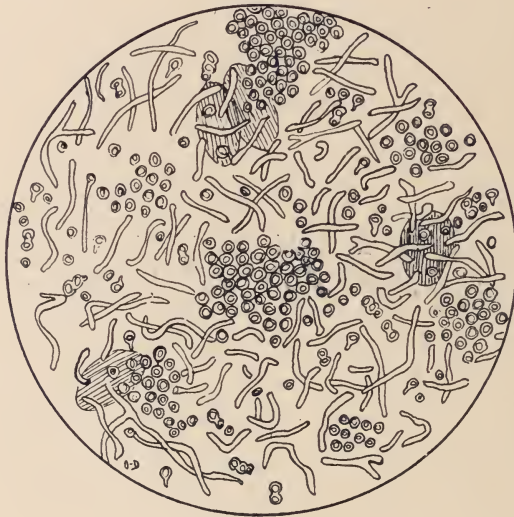
In favus of the body a small area, such as the knee or elbow, may be the only portion involved, or it may attack the entire body, as shown in Figure 1. It will be seen in this figure that the lesions, whilst occurring all over the skin, still retain their discrete distribution. Another peculiarity, and this is one which renders the case more interesting, is that the lesions are very large—one or two inches in diameter. In spite of this large size they remained cup-shaped and, as the figure shows, they were very thick. Of course, cases like this one are rather the exception than the rule, but serve to demonstrate very forcibly how the parasite will flourish on a soil which is favorable to its growth—heat and moisture—as well as not disturbing the lesions contributing largely to this exuberance in formation and increase. It will be further observed that there is no ocular evidence

of the presence of any marked degree of itching, which is usually the rule in favus corporis to a certain degree. Had there been itching the scutula would have been more or less torn off or at least broken up, and this would have shown up distinctly.

When favus occurs upon the scalp or any hairy part, each cup is pierced by one or more hairs at its center. When it is the scalp which is affected the hair becomes dry, lusterless and brittle to a degree. It is this last peculiarity which gives rise to the formation of patches which have a surface more or less brush-like in appearance on account of the broken-off hairs. This breaking-off occurs about one-eighth of an inch above the level of the scalp, and the height of the hair stumps is pretty uniform and level. Nor is this the only thing; for, if the process has been going on for any considerable length of time, it is by no means unusual to find spots here and there totally devoid of hair. All of the characteristics mentioned are well shown in Figure 2. This is caused chiefly by the scratching which is a natural result of the itching of a more or less marked character which is the most prominent symptom and is invariably present in this locality. The scratching not only produces a breaking down of the hair, but it also breaks up the friable crusts. Furthermore, it is very active in transferring the disease to other points. In addition to this it causes the finger-nails to become involved, giving rise to onycho-mycosis favosa. The nails then become yellowish in color, dull in appearance, markedly thickened and brittle. They are also quite friable and are a constant menace as a source of infection, not only to the affected individual but to others who may come in contact with him. A peculiarity to be more especially noted in connection with favus of the scalp is the fact that it possesses a very peculiar odor. This peculiarity is one so marked that it has been looked upon as pathognomonic by many observers, and when perceived it should immediately arouse suspicion and lead to very careful clinical and microscopical examination. The odor is one which must be smelled to be appreciated. It is compared by some to that emitted by stale straw, whereas others compare it to that of a mouse's nest. Others have made different comparisons, such as wet hay, and it is for this diversity of opinion in judging the odor that it is best for each one to acquaint himself with it, as it is undoubtedly one which is, beyond question, *sui generis*.

The diagnosis of favus should be a comparatively simple matter when an unbroken and unaltered scutulium can be found. But, unfortunately, this is not often the case. It is so frequently the case that an affected patch has had all the cups broken that all that is presented is a grumous-looking crust, of a disagreeable, often sour, odor, with here and there suppurating points. Under such circumstances it is frequently the case that one well acquainted with the characteristics of the disease is unable to formulate an absolute diagnosis. A method by which a diagnosis may be arrived at is by means of auto-inoculation. Another method is to make a pure culture upon a suitable nutrient medium. But either one is defective in one result, so far as a practical application can be made: it takes too long a time to obtain a growth characteristic enough to establish a diagnosis; so that it is best to resort to a method which is both rapid and positive, as well as reliable, for this purpose. By this method, which can be carried out in a comparatively simple manner, the presence of the par-

asite causing the disease is disclosed. The parasite is a vegetable fungus, known as the achorion schœnleinii, and is composed of mycelia and spores. The modus operandi of the examination is, in brief, as follows: A small portion of the material to be examined is subjected to the action of official liquor potassæ for a short time. The object of using the liquor potassæ is to render whatever epithelial cells are present and the fungus transparent, bringing out the contours distinctly. After the preparation has become sufficiently translucent it is washed with water, and then dehydrated with alcohol. Clearing with oil of cloves and mounting in balsam makes a permanent preparation. Of course, if it be desired, the growth may be stained; but for purposes of diagnosis this is unnecessary. In fact, for a rapid examination, it is unnecessary to make a permanent mount. Upon examination the mycelia and spores can be easily made out with a one-fifth inch objective and a two-inch eye-piece. The peculiarity



• FIG. 3. Achorion Schœnleinii.

of the parasite is that it consists of long mycelia and disseminated spores. A fair idea of the appearance is given in the diagram shown in Figure 3. The mycelia are long, branched and interlaced, as well as quite numerous. The spores, or conidia, are superficial, and are scattered here and there. They may also be found inclosed in mycelia which have the distinctive name of sporo-fores. In the picture given, epithelial cells may be seen, and it is that generally presented by the superficial or epiphytic form of the parasite. The hypophytic is the deeper form, such as occurs in follicles, and more commonly in hairs. In the latter case there exists an infiltration of mycelia in the bulb and for some distance above the level of the scalp. The mycelia lie in the hair in a direction parallel to its axis. It could not by any means be mistaken for ring-worm of the hair, for here there is an infiltration of small spores in chains, and these chains are closely packed to one another, whilst no mycelium can be detected.

The treatment of favus is a matter requiring some considerable care and attention to details. Care is necessary in order to avoid producing a spread of the disease in the efforts which are made to destroy the parasite, and the details of treatment are to be strictly followed in order to prevent the occurrence of relapses which will certainly take place if the smallest portion of the parasite is left to flourish. Difficulty will also be experienced in destroying the hypophytic form, and unless the deepest infiltration be efficiently reached a recurrence is certain to take place, and, in the case of hairy portions, permanent baldness will ultimately result. So that the first thing to be understood is that the treatment, to be successful, should be thorough.

The first thing to do, in any event, is to remove all crusts thoroughly. This affords a better surface for the remedy to act. In case of the epiphytic form of the disease it is much easier to procure a rapid result. A good parasiticide should be employed, and there are many to choose from. Campho-phénique liquid is most efficient, but care is to be taken to see that the surface to which it is applied is dry. This agent is to be applied twice daily. Another parasiticide is corrosive sublimate, which often acts very efficiently. A good method of applying it is in the following form:

℞ Hydrarg. bichloridi.....gr. i
Tinct. benzoin.....ʒ i
M. Ft. sol. Sig.—Apply with a brush once a day.

If a large surface is involved, an application which is neither irritating nor toxic is the following, which has served me well on numerous occasions:

℞ Losophan.....ʒ i
Axungiae perci.....ʒ i
M. Sig.—Apply twice a day.

In applying the ointment an essential point is that it be well rubbed in. It is not necessary to use large quantities, as such a course would not hasten the cure.

In the case of favus of the scalp more thorough measures are to be employed. In the first place, the hair greatly impedes the proper application of remedies. If the favus is in patches it is best to practice epilation. The manner of doing this is somewhat difficult to accomplish successfully unless a proper forceps be employed. The best for this purpose is Piffard's, which is shown in Figure 4. The affected hair is grasped near to the scalp and carefully pulled out, and in this manner, by pulling out a number, a denuded spot is soon made. The healthy hair surrounding an implicated area is also epilated for a distance of about a quarter of an inch and in this manner prevents any further spread of the disease. If the entire scalp be affected, then a method superior to epilation is to shave off all the hair. A preliminary shampoo with *sapo viridis*, well rubbed in, will be found to be a most excellent detergent. The scalp having been cleared by either method, local measures may be used with some chance of obtaining a success. The best applications are without doubt those in the form of an ointment. A fatty excipient will more readily permit of a remedy penetrating into a hair follicle than an aqueous or alcoholic solution. The method to adopt, however, is to first thoroughly cleanse the affected part with tincture of *sapo viridis* and then rub in the ointment well and for

quite a time. This should be done twice daily. Among the ointments which may be used is the one given above or one made as follows:

℞	Acid salicylic	℥ i
	Hydrarg. bichloridi	gr. i
	Vaselini	℥ i
M.		

Chrysarobin has been used with a measure of success, but it has the disadvantage of staining the skin and frequently brings on an artificial dermatitis of more or less severity. On the other hand, there is an agent which has been highly spoken of, claims being made that three or four applications will effect a cure in cases where the scalp is affected. This is simply formalin in solution of 1 to 1000 to 1 to 500. If used stronger



FIG. 4. Piffard's Epilating Forceps.

than the latter it is apt to prove very painful as well as irritating, although some bear a much stronger solution without apparent inconvenience.

Whilst not really a portion of the treatment the prophylaxis or prevention of the spread of the disease is no less important. The physician should never lose sight of this point. The individual who has favus should be kept from coming into contact with those who are unaffected, and the exchange, even temporary, of toilet articles or portions of clothing, hats and caps, strictly prohibited. Not only this, but these articles should be also subject to such treatment as will effectually kill the parasite. In this way the further spread of the disease and auto-inoculation may be prevented.

TO THE COUNTRY DOCTOR.

Thou Angel of a people's weal, how strong
 The hold thou hast upon a people's heart!
 No taint of busy world's commercial mart
 Unto thy glorious calling doth belong.

Swift to attend, to succor, heal and soothe,
 Commissioned by a calling from above,
 Untiring in thy labors full of love
 Thou dost life's rugged pathways live to smooth.

Beyond all greatness of ambition born,
 Thy glory shines like some still Pharos light;
 Though silent and alone, thy deeds adorn
 The character of man with glory bright.
 Though humble be thy calling here on earth,
 The Great Physician will proclaim thy worth.

—Thos. Osmond Summers.

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ALLISON, W. R., Peoria, Ills., PRACTICE.	LAFORCE, W. B., Ottumwa, Iowa, PATHOLOGY.
BALL, JAMES MOORES, OPHTHALMOLOGY.	MINGES, GEORGE, Dubuque, BACTERIOLOGY.
BLACKMER, R. C., C. M., MEDICAL JURISPRUDENCE.	OHMANN-DUMESNIL, A. H., DERMATOLOGY.
CALE, G. W., F. R. M. S., SURGERY.	PAQUIN, PAUL, THORACIC DISEASES.
CERNA, DAVID, Galveston, Tex., MEDICAL HISTORY.	PHILLIPS, G. M., GENITO-URINARY.
COULTER, J. HOMER, Chicago, RHINOLOGY.	ROBINSON, F. BYRON, Chicago, GYNECOLOGY.
HEFLEBOWER, R. C., Cincinnati, OTOLOGY.	STRAUS, LEON, PROCTOLOGY.
HILL, ROLAND, PEDIATRICS.	THOMPSON, G. H., THERAPEUTICS.
JENKINS, J. F. T., C. M., M. D., Los Angeles, CLIMATOLOGY.	VOLDENG, M. N., Des Moines, NEUROLOGY.

THE MISSOURI MEDICAL LEAGUE.

We are pleased to note that the non-college element in the local profession is getting into shape to bring about some needed reforms. The recent establishment of the Missouri Medical League shows that these gentlemen are up and doing. Modeled after the New York Medical League, the Saint Louis Society will work for the enlistment of all under one banner who favor more stringent regulations as regards the admission to and graduation from schools of medicine. Already such strong men as Robert M. Funkhouser, P. D. Conolly, Robert H. Finley, Wheeler Bond, W. V. Loftus and Thomas O'Reilly have met and organized an association which is certain to do much good. They are all men of strong character and sterling worth and have the courage of their convictions.

The League will endeavor to impress upon doctors, first of all, the necessity of being good citizens; *i. e.*, the importance of voting and taking a stand in all elections. This is most commendable, for the time has now come when the members of the profession should have an influence in shaping legislation as regards the public health and the welfare of the profession. The League will also endeavor to suppress the abuse of medical charity, endeavor to aid in securing a National Department of Public Health, attempt to secure a State Board of Medical Examiners, and bring about a state of fraternity among the members of the medical profession.

We wish the Missouri Medical League much success.

CONCERNING OUR SCOOP.

The exclusive publication in our last issue of the report of the committee of the Saint Louis Medical Society appointed to investigate the abuse of medical charity is bearing fruit. Already journals aggregating a circulation of 30,000 copies have expressed their intention to reprint the report. This means that every doctor in the great Mississippi Valley will know the sheep from the goats, will be able to spot the violators of the rights of the medical profession, will know where to send medical students this fall, and will know whom to avoid in consultation work. The sanitariums which are engaged in trafficking in religion will have to cease stealing the patients of country doctors and stop sending their reverend drummers and quackish literature to laymen. It means soon a better and nobler profession. It means that the present agitation will be continued until every ethical quack cries for quarter. It means that the abuse of medical charity by the two oldest medical colleges in this city, viz.: the St. Louis Medical College and the Missouri Medical College, must stop. It means that the day will come soon when to be a physician will be a greater honor than to be a king: for the Bigwigs are scattering like goslings driven by a storm, and many a man who looked wise, was considered pure and ethical, and, of course, thought himself so, is found to be filled with the greed of selfishness and there is no health in him. So long as the present abuses continue the fight is on.

EUREKA SPRINGS, ARKANSAS.

This charming health resort is nestled among the hills and mountains of Northwest Arkansas. It is an ideal spot in which to rest. The air is good, the water pure and palatable and possesses remarkable curative properties; the hotels are all that could be desired; the scenery is beautiful; the inhabitants are noted for their boundless hospitality, and expenses are moderate. We do not know of any place where the invalid and the rest-seeker can get so much for his money as in this Arkansas city of four thousand inhabitants.

And this resort is only one night's ride from Saint Louis.

A delegation of physicians and their wives was recently entertained by the citizens of Eureka and were the guests of the famous "Crescent" hotel. They came back singing the praises of Mr. John Oliver Plank and his able assistants, Messrs. A. H. Hilberts and P. K. Cheseldine. Particular mention should be made of the hospitality of the local physicians, viz.: Doctors Floyd, Bolton, Ellis, Miller, Davis, Sprague, J. B. Ellis, Jordan, Hardesty, Hayes and Regan.

The thanks of the delegation are also extended to the "Frisco" Railway, which maintains a magnificent service between Saint Louis and Eureka Springs. And our cry will ever be:

"Ki-yi-yi
Mizzouri,
Eureka Springs,
Rye, rye, rye
And a high ball."

WHERE WILL YOU SEND YOUR STUDENTS THIS FALL?

Doctor, this is an important matter. It is of moment to the young man who asks you for advice; it is of moment to that vast army of physicians who find the practice of medicine anything but a lucrative occupation. These men do not fear an honest competitor, one who has thoroughly prepared himself for the duties of the doctor; but they do not like to be brought face to face with one who is ill prepared to begin the study, and who perhaps has graduated from a school where diplomas are easily obtained.

Whatever you do, do not send a student to a college where the "fessors" are known to treat well-to-do patients free of charge.

END OF THE WESTERN POLYCLINIC.

It has oft been said that the good die young. If this be true the Western Polyclinic must have been exceedingly good, for it is dead after a very brief career. The world will stand still until the originator of the late lamented springs his next sensation upon an expectant medical public.

The death of the Western Polyclinic is probably the direct outcome of the report which was recently made to the Saint Louis Medical Society by its committee on the abuse of medical charity. Let the good work go on. There is in this city another "Polyclinic" which might die and leave few mourners.

THE THIRD REPORT.

The committee of the Saint Louis Medical Society appointed to investigate the clinics, dispensaries and colleges of this city with reference to the abuse of medical charity made certain recommendations for the cure of existing evils (which were explicitly mentioned in our last issue).

Before receiving the third and last report the society passed a resolution calling upon all members of the society who belong to the condemned institutions either to cease the abuses or to hand in their resignations to the Saint Louis Medical Society.

The committee made, as its recommendations for relief, a report simply advocating legislative action to the ends: (1) A board of medical examiners to determine the qualifications of applicants for registration and to issue certificates to those passing the required examination, in the laudable hope of eventually improving the quality of physicians in the State of Missouri, but of too remote effect to be of any advantage to us of to-day; and (2) a bill regulating dispensaries, requiring them to be incorporated or licensed, forbidding their establishment in a "drug store" or a "tenement house;" providing that the word "dispensary" shall only be used in connection with an incorporated or licensed dispensary; that persons shall not obtain relief from dispensaries by false representations, and that a violation of this act shall be a misdemeanor, and also empowering the State Board of Charities to make rules and regulations and to annul or suspend incorporations and to revoke licenses.

Our reason for not printing the Third Report in full is this: Dr. Robert M. Funkhouser, President of the Missouri Medical League (a society recently organized in this city for the purpose of correcting many of the evils now existing in the profession) has promised to give our readers, at an early date, an account of the aims and purposes of the League. His paper will no doubt cover all the points in question and will be read with great interest.

HISTORICAL SKETCH.

INFLUENCE OF PHILOSOPHY OF THE SEVENTEENTH
AND EIGHTEENTH CENTURIES ON MEDICINE.

By JAMES MOORES BALL, M. D., of St. Louis.

FOR two thousand years the world had listened to the philosophers—yet but little real progress had been made. The magi of the East, the priests of Egypt, and the wise men of Greece had in turn pointed out a path which was found to be unsafe and which lead nowhere. The scholastics had befuddled the world with their abstruse speculations. It was time for a new philosophy.

The ancient intuitive method which lead to the discovery of great moral and religious truths was not calculated to advance medical knowledge. Charmed by the infallibility of mathematical reasoning the wise men sought to introduce the same methods into the sciences. Plato sought in purely abstract ideas the secret of creation and the explanation of natural phenomena. Democritus, Hippocrates, and Aristotle saw that mental reflection, apart from the senses, was unable to explain the properties of matter. Hippocrates was one of the first to declare the necessity of observation in the study of disease. Aristotle affirmed that all of our knowledge is derived from sensation. He and Plato agreed in saying that the first notions formed in our minds are very general ones—mother ideas, principles. This heresy drew these two philosophers and their acolytes into a maze of contradiction. Observation was almost forgotten; reasoning was the all in all.

Toward the close of the sixteenth century observation had partly penetrated some branches of knowledge, as physics, astronomy, and chemistry, and had produced such magnificent results that the scholastic philosophy was shaken. The time was now ripe for great minds to find a form of reasoning less defective and to bring about a revolution in philosophy.

FRANCIS BACON, LORD VERULAM, 1561-1626.

The doctrines of Francis Bacon were of great importance in the development of philosophy, natural science, and medicine. As exalted in mind as he was mean in personality, Bacon forms a landmark in the history of civilization. He was the chief defender of the inductive philosophy. He was the first to teach that particular ideas are the base of the scientific pyramid, while axioms are its summit. "Logicians," says Bacon, "hitherto appear scarcely to have noticed induction, passing it over with some slight comment. But we reject the syllogistic method as being too confused and allowing nature to escape out of our hands." In the preface of the *Instauratio Magna* Bacon exhorts the reader to search for knowledge:

"If there be any man who has it at heart, not merely to take his stand on what has already been discovered, but to profit by that, and to go on to something beyond:—not to conquer an adversary by disputing, but to

conquer nature by working:—not to opine probably and prettily, but to know certainly and demonstrably:—let such, as being true sons of nature



FRANCIS BACON.

(if they will consent to do so), join themselves to us; so that, leaving the porch of nature which endless multitudes have so long trod, we may at last open a way to the inner courts, and that we may mark the two ways, that

old one, and our new one, by familiar names—we have been wont to call the one the *Anticipation of the Mind*, the other the *Interpretation of Nature*.”

Physical Experiment was the Organ or instrument which he proposed for the investigation of nature. His work was given to the world just at the time when authority and dogmatism were about to be discarded and the era of experimentation had begun. It was not his contributions to science, not his discoveries, which entitle Bacon to a high position in the reformation of science; but his connected mode of thinking, the general spirit of his philosophy, and the fact that he pointed out the various circumstances which have in all ages hindered the free and successful pursuit of knowledge. He had a contempt for the old philosophy and even rejected the astronomical theory of Copernicus and the magnetic investigations of Gilbert. William Harvey impaled him upon the lance of criticism, saying: “The Lord Chancellor wrote on science like a Lord Chancellor.” Regardless of its author’s failings the world has justly attributed to the *Novum Organon* a great influence on the development of modern science. Bacon was the first to herald the existence of a philosophy of science, to insist upon a unity of knowledge and inquiry throughout the physical world, and to announce that theology, which had absorbed the intellectual energy of the world, should not be classed in an enumeration of the branches of human knowledge. “If I proceed to treat of it,” he said of theology, “I shall step out of the bark of human reason, and enter into the ship of the Church.” Such a declaration was of vast import. England had been rent with the theology and politics of the Civil War. Before the restoration only two discoveries of importance could be credited to Englishmen, viz.: Gilbert’s discovery of terrestrial magnetism, toward the close of Elizabeth’s reign, and Harvey’s discovery of the circulation of the blood, in the reign of James. The clouds were dispersed and Englishmen at last understood the call of Francis Bacon. A spirit of scientific inquiry arose and little groups of men met to engage in experiments and exchange ideas. In 1645 several Londoners who were interested in the progress of mathematics and natural philosophy agreed to meet weekly to discuss these subjects. Three years later several of these gentlemen were appointed to situations in the University of Oxford, where a similar society was instituted. Scattered by the political changes of 1659, the members met in London after the restoration of Charles II., and on the 28th of November, 1660, formed themselves into a society for the promotion of all kinds of experimental philosophy. In this humble way the Royal Society of London had its origin. It is not too much to say that this honorable body has wielded an influence greater than that of any other scientific society. In 1662 Charles II. made it a body politic and corporate. In 1664 the publication of the *Philosophical Transactions* was begun. “Our business,” said Dr. John Wallis, one of the founders, “was (precluding matters of theology and State affairs) to discourse and consider of philosophical inquiries and such as related thereunto, as Physick, Anatomy, Geometry, Astronomy, Navigation, Statics, Magneticks, Chymicks, Mechanicks, and Natural Experiments: with the state of these studies as then cultivated at home and abroad. We then discoursed of the circulation of the blood, the valves in the *venæ lactæ*, the lymphatic vessels, the Copernican hypothesis, the nature of comets and new stars, the satellites of Jupiter, the oval shape of Saturn, the spots in the sun and its turning on its own axis, the inequalities and selenography of the moon, the several phases

of Venus and Mercury, the improvements of telescopes, the grinding of glasses for that purpose, the weight of air, the possibility or impossibility of vacuities, and nature's abhorrence thereof, the Torricellian experiment in quicksilver, the descent of heavy bodies and the degree of acceleration therein, and divers other things of like nature." Surely Bacon had not written in vain. Science suddenly became the fashion of the day: wits and courtiers, warriors and statesmen, kings and princes, attended the meetings of the Royal Society.

RENÉ DESCARTES, 1596-1650.

The philosopher whose teachings and discoveries have left the greatest impress upon the development of modern medicine was René Descartes. Bacon advocated the inductive method. Descartes taught the deductive philosophy. Bacon pointed the path to be followed by discoverers; Descartes not only blazed the way for others, but made many important contributions to science. Some men are great because they mirror the actuality of their own age; others are great because "they embody the potentiality of their own day, and magically reflect the future. They express the thoughts which will be everybody's two or three centuries after them. Such an one was Descartes."

Although Descartes was himself the founder of a sect of philosophers he pursued his researches in such a free and independent spirit as to entitle him to rank with the Eclectics. To him we owe the first correct explanation of the rainbow and the laws governing refraction.

Brushing aside the whole framework of Peripatetic philosophy, Descartes supplanted the ancient logic by a sure rule which may be thus stated: "The mind may affirm of a thing all that is embraced in the idea of that thing, or evidence is the only certainty of the truth of our judgment." He said that the universe contains: (1) Matter with its characteristic property of extension; and (2) mind with its characteristic property of thought. Between these there is no conceivable connection. Conscious thought is the only proof of the existence of mind—*Cogito, ergo sum* (I think, therefore I am). The processes of life, however, may go on without conscious thought. Hence, vital activity is purely mechanical. Descartes asserted that animals were merely automata or self-acting machines, while man is a similar machine to which a mind is added. "The animals act naturally and by springs, like a watch." "The greatest of all prejudices we have retained from our infancy is that of believing that beasts think." This theory did much to encourage vivisection—a practice common with Descartes and his followers. They held that the sentience of an animal to the knife is not other than the sensitivity of a plant to the influences of light and heat. "I will not believe that a beast thinks," said the Cartesian Chanut, "until the beast tells me so itself."

Descartes dissected the heads of animals in order to explain imagination and memory, which he regarded as physical processes. In the Cartesian view the body was a machine and physiology a department of physics. He embraced Harvey's newly-enunciated discovery of the circulation of the blood, made vivisections to prove its truth and did much to popularize it, since it fell in with his mechanical theory of life. He said that science may be compared to a tree; metaphysics being the root, physics the trunk, and

the chief branches mechanics, medicine and morals. The Cartesian philosophy dominated the medical theories of the seventeenth and part of the eighteenth centuries. The physicians of the seventeenth century attempted to solve the problems of life upon purely materialistic principles—the one by the aid of chemistry, the other by the assistance of mechanics. Hence arose the two chief schools of medicine known respectively as the Iatro-chemical and Iatro-mechanical. The typical representative of the former was Sylvius de la Bœe, while to the latter we must assign Sanctorius, Borelli, Bellini, Baglivi, Danzellini, Sauvages, Senac, Boerhaave, and Pitcairne.

Descartes was not only a great philosopher and one of the greatest and



RENÉ DESCARTES.

Portrait by Franz Hals.

most original of mathematicians, but he is entitled to the highest rank as a physiologist; for he did for the physiology of motion and sensation what Harvey had done for the circulation of the blood. Descartes advanced the mechanical theory of these processes. The foundation of the modern physiology of the nervous system was expressed by Descartes two hundred and fifty years ago. He held that the brain is the organ of sensation, thought and emotion; that the movements of animals are due to change of form of muscles, which shorten and become thicker, and that this change is due to a motion of the substance contained in the nerves going to the muscle; that the sensations of animals are due to a motion of the substance of the nerves which connect the sensory organs with the brain; that the motion of the matter of a sensory nerve may be transmitted through the brain

to motor nerves, thereby causing contraction of muscles to which these motor nerves are distributed; that this reflection of motion from a sensory into a motor nerve may take place without volition, or even contrary to it; and that the motion of any given portion of the matter of the brain excited by a motion of a sensory nerve, leaves behind a readiness to be moved in the same way in that part. Anything which resuscitates the motion gives rise to the appropriate feeling. This is the physical mechanism of memory.*

[TO BE CONCLUDED IN OUR NEXT ISSUE.]

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter V.—Continued.

GRATIS VERSUS FREE.

By the time Dr. Newcomer had been in the city ten or twelve years he bought a share in a new practitioners' college, which included a professorship in surgery; he was also elected secretary of the college. Naturally, he became the target for the good or evil with whichever the profession might be most generous.

Unfortunately, in the first announcement which was sent out by the college, was the statement that the poor might receive treatment "gratis" at the various clinics. Gratis! What a violation of the code! Here was an opportunity for discipline.

At the following meeting of the medical society an adjunct called attention to this unpardonable sin. This time it met with success. A committee of college professors on ethics were appointed to investigate the matter and submit a report.

The committee, instead of summoning the faculty or dean, referred the affair to the secretary of the college; for what reason, I cannot imagine. At any rate, the secretary, as an individual, was not responsible, and there was no way of reaching the corporation with the code. Colleges are privileged bodies. As no charge could be preferred against the secretary, the matter ended there. One old professor gave the advice: "Substitute the word 'free' for 'gratis,' or 'free dispensary,' like *other* respectable colleges." No report was ever received by the medical society from the committee.

The faculty members of the practitioners' school were glad that their secretary had been appointed to perform the operation, for they knew that his small scalpels were always sharp.

* Huxley: On the Hypothesis that Animals are Automata, and its History.

DR. SOUR.

(A Sketch from Life.)

Dr. Sour is of the type for whom it is either too hot or too cold, too rainy or too dry, too dusty or too muddy; the streets are never sprinkled to his satisfaction; everything comes at the wrong time; he rises in the morning in an ill-humor, for either he overslept himself or was wakened too soon; he neglects his prayers, finds fault with his breakfast, and makes himself generally disagreeable. He goes down to his office, lounges about undetermined what to do; waits discontentedly for the patients who come not; finally, when his office hours have ended and he is preparing to go home for his dinner, in comes a woman with a crying baby. Again Dr. Sour is angry; the woman should have come earlier or later. He inquires, in no gentle manner, what ails the child. This is exactly what the mother wishes to know of the doctor. The baby's crying becomes violent. The language of an infant is a closed book to Dr. Sour; he becomes exasperated. At last he prescribes, at random, some syrup. The mother departs with her wailing infant, and the doctor draws a breath of relief. He never again sees the child, and imagines he has cured it. Should he happen to attend the medical society on the following Saturday, he will report this interesting case in a short paper of thirteen pages, closely written on both sides. His memory is not to be trusted, therefore he has prepared these few notes. He will occupy the members but a few moments, as he has so little to say. His *moments* are elastic, reaching from 8 to 10:30 P.M. He will not go into details—he mentions every possible symptom and sign (that he did not find), makes numerous quotations from authors at his disposal (possibly Smith and Neal, of ancient date). Dr. Sour also speaks of those things which might have been there, but were not. However, one thing is sure—the baby cried most pitifully. One-half of the members took a siesta, the other half smoked and discussed the races; all were indifferent; no discussion followed his interesting case of the crying baby; the doctor's wonderful tact and remarkable judgment go unpraised, and when the meeting adjourns he leaves in disgust, and inwardly exclaims: "That medical society is no good; those fellows take no interest in a man's case." Dr. Sour expects every one but himself to be interested in the baby. He goes home and retires, but cannot sleep; possibly he is kept awake by thoughts of the code. After tossing restlessly for several hours, he falls into a light doze, which is shortly disturbed by the night bell. Dr. Sour slowly comes to. Scrambling out of bed, he makes an unsuccessful search for his slippers. Where can his trousers be? An oath leaves his lips. Finally he strikes a light and admits the messenger, whom he assaults with twenty-five questions. When he reaches the house of the patient, everything again is wrong. With his usual abruptness he writes a prescription, and orders it to be filled at some drug store way down town, for that is the only place to obtain pure drugs. Dr. Sour leaves with or without his fee, as the case may happen. He omits saying "good-night." The patient and her friends are so well impressed by the doctor's courtesy and skill that they decide to send him a note. In the meantime Dr. Sour congratulates himself upon having such a desirable case to attend. Alas! morning brings the note (delivered by the hands of a valet), which reads: "Need not call again."

Dr. Sour decides "Being a doctor is purgatory. Everybody is at fault. Perhaps the pharmacist has charged too high for the medicine, or some one has interfered." However, Dr. Sensibly Sweet is called to the lady and maintains the case till recovery, thereby obtaining the practice of the family and many of the neighbors. Now, Dr. Sour cannot understand such a change in events, but in looking over the code he finds it. "That doctor prescribes for my patient without consulting me; shall bring charges. Then, there is the druggist next door, who prescribes over the counter. We want more and better laws." Dr. Sour has no appetite for breakfast; in looking for faults he finds them. Seating himself in an easy chair, he picks up the Sunday morning paper. He looks through it, expecting to see his name and a full report of his case. Again he is disappointed. He will make a motion that, in the hereafter, the reporters be excluded. If they *had* happened to mention his case, he would have been wrongly quoted; he is *never* understood. He makes such a commotion with the paper that the cat is startled out of her doze. He throws down the paper, impatiently exclaiming that "there is no news in those twenty-four pages." Dr. Sour turns his attention to his medical journals. He glances through a specimen copy of the *Medical Trinity Journal*. It meets with the same treatment as the newspaper. "These one-dollar journals are no account—nothing but advertisements." He takes up another with a looking-glass upon the cover and a smiling little face within. He finds something under the heading of a Pot. "Well, this may do—it is a lovely one-dollar journal, but I do not like the editor." Next comes a four or five-dollar journal; Dr. Sour tries to become interested in an article. "This is too deep and too long; too much about serum, toxins and bacilli." He does not understand all this humbug, and therefore does not believe in it. He wishes that some one would get up a good journal—that is, a good specimen number, for he does not subscribe for any journal. Everything to suit him must be brief.

In the evening Dr. Sour searches for a remedy for Bright's disease. He examines all his samples, trial bottles and tablets, which he brought home from the last State medical association. He cannot find anything to suit, and condemns all patent medicines. Now he searches through all the advertising matter on hand, and cannot find the right thing. Hello! here is a specimen copy of a journal that has not been opened. Off goes the cover—here we are! But *this* journal contains no advertisements; he is upset completely; the unfortunate journal is cast into the fire-place, for that is all it is worth, containing no legitimate advertisements. "Why are there none in it, so a fellow can find a remedy for Bright's disease?" No remedy forthcoming, it is substituted by a death certificate.

Dr. Sour now becomes bitter. The neighborhood is no good; there are too many doctors. He moves into another locality, and, like the bird of passage, keeps on moving. If he were only a professor and connected with some school, he would be all right.

So, Dr. Sour goes on finding fault *ad infinitum*, and ekes out a miserable existence until the Lord has mercy on him.

If Dr. Sour happens to be a woman, then God pity those who share the roof-tree with her.

Why not reverse all this, and be Dr. Sensibly Sweet, always contented?

[TO BE CONTINUED.]

REPORT OF THE FORTIETH ANNUAL MEETING
OF THE
Missouri State Medical Association,
HELD AT

Century Theater Building, St. Louis, May 18, 19 and 20, 1897.

(CONTINUED FROM JUNE ISSUE.)

Afternoon session convened at 2:30 P. M.

President Duncan announced that the British Medical Association had sent a very cordial invitation for this Association to send delegates to their coming convention in Montreal. Motion was made and carried that the president appoint delegates. President deferred appointing delegates, as he only desired to appoint those who would care to go.

Miscellaneous business was attended to.

Paper—"Surgical Tuberculosis"—was read by Dr. L. T. Riesmeyer, of St. Louis. He said: This subject includes many conditions, but I will confine myself principally to my own experience and observation. The surgical maxim advanced, that as soon as a diagnosis is made of local tuberculosis the diseased portion is to be removed by radical operative measures, has been modified. We now recognize the fact that good hygienic surroundings are a great factor in the ultimate success of an operation. I have used a five per cent. solution of carbolic acid or an emulsion of iodoform, injected locally, but have not had much success, as the solutions do not reach every part of the infected area. The disease in children is usually located in the bones and joints. Results from operative procedures are better in children than in the adult. After the capsule of a gland has ruptured the proper treatment is a clean incision affording free exit to the pus. He said: I have had good results from total extirpation of sheaths of tendons in primary tuberculosis; also in operations on the female breast and on the testicle.

Dr. J. F. Bryson, St. Louis, read a paper on "The Subjective Symptomatology of Renal and Ureteral Disease." He said the ureter is within the domain of operative surgery. For convenience he divides the ureter into three divisions, viz.: the upper, middle and lower portions. The statements of the patient cannot be relied on, but we must have a definite plan as a hypothesis in diagnosis. The passage of a calculus along the course of the ureter, as it descends from above downward, has been traced with a great deal of precision, for it carries with it a train of symptoms directly referable to the upper, middle and lower portions of the ureter. It is often possible to diagnose between calculus in the kidney and ureter. He cited a number of cases, the first being in a lady forty-nine years old. No history of previous renal disease; constant desire to urinate, followed by severe muscular effort, which was relieved when in the recumbent posture. Pressure upon and instrumentation of the ureter well borne, with no increase in pain; bladder empty; symptoms were relieved by the use of

cocaine Diagnosed calculus in left orifice of ureter. Entire relief from all symptoms was obtained one-half hour after the passage of a calculus. There was pain in left ureter at the opening into the bladder. Case 2. A woman thirty years old. Had frequency of urination without tenesmus; relieved when in the recumbent posture; had not been free from a constant desire to urinate for several months. One day she felt something "give way" in the left side, followed by increased flow of cloudy urine. A few hours later three calculi were passed. (Exhibits specimens.) The woman was relieved for a time, but soon had pain in the right side; urine became cloudy and there was some enlargement, the bladder was inflamed, tenderness on pressure, the pain radiating from the middle of the ureter. No disturbance along the course of the genito-crural nerve. The renal crises were severe enough to cause emesis. Performed nephrolithotomy, making the incision in the right lumbar region, extra-peritoneal. (Exhibited specimens.) He cited four other cases in which he had been able to make a diagnosis as to the exact position of the calculi. He said if a localized inflammation gives rise to any symptoms the pain will radiate along the distribution of the renal nerves. He then gave some anatomical points on the blood supply and distribution of nerves of the kidney and ureter. The distribution of these nerves accounts for the pain during renal crises and causes the pain referable to the different parts of the ureter.

Dr. N. B. Carson, St. Louis, read a paper on "Intermittent Hydronephrosis." He said cases of hydronephrosis are very rare, so rare that no one man has a sufficient number to report, and he must depend on the cases of others. Hydronephrosis is a distension of the kidney with water. Hydronephrosis may be congenital or acquired, unilateral or bilateral, constant or intermittent. If infection takes place it is usually from below upward, and in such an event pyonephrosis is the result. Congenital causes do not always give rise to symptoms in infancy. He told of several cases in his own practice and those of other physicians that had come directly under his notice. It sometimes happens that the fluid is colloidal in character. There are usually degenerative changes in the parenchyma of the kidney. Treatment is wholly surgical, which consists in removing the obstacle and establishing the flow of urine. Massage is recommended, but the relief is, at best, only temporary. He said he had in his practice used massage with other remedies and did not know what did afford relief. The relief after aspiration is only temporary and is only used as a means of diagnosis. Incision and drainage have been of use in some cases, but this procedure usually causes a fistulous opening. Nephrectomy is the ideal operation in these cases if you are certain the remaining kidney is healthy and can carry on its physiological office. Drainage is not recommended unless complete removal is impractical.

DISCUSSION.

Dr. Cordier, of Kansas City, said the subject Dr. Bryson presented is very little understood, but we are making advancement both in diagnosis and treatment of these conditions; we are treating more scientifically. To be able to explore the bladder and catheterize the ureters, to find whether there is obstruction in one or both, is certainly a long stride onward in the science of medicine. These cases of Dr. Bryson show great skill in mak-

ing a diagnosis. He did not agree with Dr. Carson in regard to it being the better plan in cases of hydronephrosis to remove the kidney, if possible, for it is remarkable how the kidneys will regain their function. He cited a case in which a movable kidney had been the cause of a great deal of disturbance: after making an incision into the abdominal cavity with the intention of draining, and before he got to the kidney, he noticed the enlargement had diminished, and by the time he reached the kidney had disappeared altogether. He placed the kidney in its normal position and sutured it, and the patient recovered. The cause of this condition was a kink in the ureter, and when it became unkinked the fluid passed into the bladder and the enlargement disappeared.

Dr. Bransford Lewis, of St. Louis, said the enlargement of a kidney and then the passage of a large amount of urine is due to the unkinking of the ureter. We sometimes have the same condition during shock; it is also sometimes caused from congestion of the kidney from nervous influences. Sometimes the bladder is filled to overflowing on account of the congestion and increased blood pressure.

Dr. Hugo Summa said the cases of intermittent hydronephrosis are not so rare as Dr. Carson considers them. They are often found and especially in women, on account of the anatomical arrangement of the organs. The tubes become perforated or absorbed and the contents of a cyst are sometimes taken up and excreted through the vagina. He cited cases of such condition.

Dr. Jacobson, of St. Louis, said, in discussing Dr. Carson's paper: Inflammation of the bladder wall will cause a contraction of the ureteral wall and as a result the urine is dammed back and hydronephrosis is the result. The seminal vesicles extend from the base of the bladder to the ureters, these vesicles, becoming inflamed, may by their proximity to the ureters cause contraction, thus again causing the urine to be held back and have hydronephrosis.

CLOSING REMARKS.

Dr. Bryson said: Ordinarily hydronephrosis is intermittent, and this intermittent contraction of the ureter is the cause of the hydronephrosis. Certain nervous conditions bring about symptoms which lead one to make this diagnosis; for instance, polyuria of a low specific gravity; yet if an operation were performed would not find a hydronephritic kidney. It is not advisable to operate in cases where there is no inconvenience to the patient. Deformities are found to be more frequent than we previously considered them. There are changes in the number of ureters; the arterial supply varies; there may be abnormalities in the infundibula or calices of the kidney. He said: I tried the X-rays on a kidney in which I expected to find a stone, but none was demonstrated by this means, yet in operating I found a stone. He employed the X-rays in another case: apparently there was a stone, yet in operating he found none.

Dr. Carson, in closing, said the mouth of the ureter is liable to be contracted on account of the oblique manner in which it opens into the bladder. Any narrowing of this opening will cause the urine to be held back and as a consequence the urine will be stored up in the kidney. Movable kidney is a frequent cause. He cited a case on which he had

operated twelve years before: the kidney could be moved all through the abdominal cavity; it was so large he thought it was a tumor with a very long pedicle. After a few years he operated again, intending to bring the kidney into its normal position and suture: on incision, instead of finding a dilated kidney, found it contracted. Several cases have been reported where ovarian cysts were mistaken for hydronephrosis on account of being excreted through the vagina.

THE SILVER TREATMENT OF WOUNDS.

By HOFRATH DR. CREDE, Divisionsarzt à la Suite, Chief of the Surgical Division of the Carola Hospital in Dresden.

I. PRELIMINARY REMARKS.

The silver treatment of wounds is based upon the well-known facts that silver and its salts possess pre-eminent antiseptic properties, and that they are at the same time entirely non-poisonous to the human organism. In my essay entitled "Silver and the Silver Salts as Antiseptics," Leipzig, F. C. W. Vogel, June, 1896, I have given the reasons for their bactericide action; have detailed the properties of the various argentic salts; and have described their application to surgical diseases and the healing process that takes place under their use. I refer the reader to this publication for particulars. My experiences since that time with 1,500 more patients confirm every assertion that I have made, and I feel that I am now in a position to elaborate the method, and to formulate it as a definite system of treatment. The outlines of this system I propose to sketch in the following lines. It goes, of course, without saying that each case must be treated according to its individual requirements, and that in each specialty certain modifications will be found necessary. Elsewhere I shall consider the subject of the various infectious diseases in which, to my mind, silver has undoubted and important effects. My method of the silver treatment of wounds is applicable in war and in times of peace; to hospital as well as to private practice; in every part of the body; and to every kind of wound. By it the best imaginable results can be obtained; and, finally, its execution is very simple, cheap, and economical in the expenditure of time and strength.

2. MATERIALS EMPLOYED IN THE SILVER TREATMENT OF WOUNDS.

1. **Citrate of Silver**, chemically pure (arg. citr. puriss.), a white, stable, odorless, non-irritating powder, soluble in the proportion of 1-3800 parts of water. This is the chief antiseptic for wounds; for, the smallest quantity of it dusted upon a lesion keeps it permanently sterile. In solution of 1 to 4-8000 it is employed for the irrigation of the cavities of the body.

2. **Lactate of Silver**, chemically pure (arg. lact. puriss.), a white, permanent powder, soluble 1 part in 15 of water. In the solid form it is somewhat irritating, and it is most useful for the preparation of disinfectant solutions of the strength of 1 to 100-2000, and for the preparation of silver sutures and drains.

In the fluids of the animal body both salts show a greater antiseptic power than does the sublimate, without having its disadvantages. Watery solutions are best made twice as strong as those of sublimate to have about the same effect.

3. **Tablets of Citrate of Silver** of 0.1 grm. ($1\frac{1}{2}$ grains), for the convenient preparation of solutions for irrigation, injection, and gargles.

4. **Tablets of the Lactate of Silver**, each 0.2 grm. (3 grains), to be used instead of sublimate tablets.

All these four preparations are made by the "Chemische Fabrik von Heyden," Radebeul, near Dresden.

5. **Silver Gauze**, a muslin evenly, powerfully, and permanently impregnated with metallic silver; it develops its antiseptic properties wherever the tissue fluids form acids, which unite with the silver to form the antiseptic salts. This occurs, for instance, during the life action of the schizomycetes, and continues as long as any silver is present. It is not necessary to use it in wounds that have been dusted with the citrate of silver; ordinary sterilized gauze is sufficient here. In cases where this has not been done, it forms an unchangeable and ever-clean dressing, which in itself disinfects smaller wounds, and keeps non-infected larger ones sterile. It is especially valuable for use outside the larger hospital centers, and is prepared by Max Arnold in Chemnitz.

6. **Citrate of Silver Bougies**, prepared from pure cocoa butter, and containing two per cent. of the citrate. They are valuable for the disinfection of deep fistulas, the urethra, the bladder, the uterus, etc.

7. **Silver Silk, Silver Catgut, and Silver Drainage Tubes.**—These can be prepared by the physician himself or by any manufacturer of surgical dressings. The raw material, without any special preparation, is put in a wide-mouthed, brown-colored glass bottle containing a one per cent. solution of the lactate of silver. Silk should remain immersed therein fourteen days, catgut and drains eight days; then the material should be taken out, thoroughly rinsed in ordinary water until the latter remains clear, and then exposed to daylight until it becomes blackish-brown in color. It is to be preserved well wrapped in several thicknesses of gauze; and immediately before it is used it should be laid for a few minutes in boiled water and rinsed therein. Silk and catgut can be appropriately kept in alcohol. The silver that they contain make the ligatures antiseptic of themselves, where that is necessary.

3. DIRECTIONS FOR CLEANSING.

For Physicians and Nurses.—1. Thorough soaping and scrubbing of the hands and forearms, special attention being paid to keeping the nails short and smooth.

2. Rinsing with pure lukewarm water.

3. Washing and brushing the hands and forearms with a solution of the sublimate 1 to 2000, or of the lactate of silver 1 to 1000.

4. After each contact with non-disinfected articles, washing of the hands with soap and rinsing with pure water.

For the Portions of the Patient's Body That Have Been Injured or Are the Seat of Operative Procedure.—1. A general bath some time during the twenty-four hours preceding the operation.

2. Soaping and shaving of the field of operation.

3. Rinsing the same with boiled water.
4. Brushing or rubbing the same with ether.
5. Rinsing with boiled water.
6. Brushing or rubbing with sublimate solution 1 to 2000, or lactate of silver solution 1 to 1000.
7. Rinsing with boiled water.
8. Covering the neighborhood of the field of operation with linen cloths which have lain in sublimate water 1 to 2000 for ten minutes immediately before the operation, or which have been boiled.
9. During and after the operation protective cleansing of the field of operation with 1 to 2000 sublimate, or 1 to 1000 lactate of silver solution.
10. Cavities are to be irrigated with 1 to 500-2000 lactate of silver, or 1 to 4000 citrate of silver solution.

4. TREATMENT OF WOUNDS.

Operative Wounds.—After the cleansing of the field the operation is performed; and several times if it is particularly bloody or dirty, and in every case at its conclusion, a gentle rinsing with 1 to 2000 sublimate or 1 to 2000-5000 solution of the lactate or the citrate of silver is done. The sublimate solution is most convenient in places, as in hospitals, where an anti-septic solution is frequently used and a stable fluid must be kept on hand. The silver salts decompose under the influence of light, and must always be prepared fresh; with the help of the tablets this can very readily be done. After hæmostasis the wound should be lightly dusted with the powdered citrate of silver; even the omentum stands this very well. The wound is then dressed with gauze, or silver gauze and cotton, and bandaged somewhat tightly. The dressings remain in place as a rule for eight to ten days. They do not require to be renewed when serum trickles through them; but they should be covered with new dressings for appearance sake. Contact of the secretion with the air does no harm. When inflammatory processes are present it is proper to use a wet dressing for the first two or three days after the insufflation of the citrate of silver, and then to apply a dry one. On changing the dressings ordinary cleanliness only is usually required.

Injuries Attended with Hemorrhage.—When possible the patient should be first bathed; when this is not practicable the neighborhood of the wound should be cleansed according to the above rules. No minute examination of the wound should be undertaken; only portions of tissue that are almost entirely detached should be cut away; and nothing should be removed from the surface of the wound even if it is dirty. Incisions are to be made only when there is very great undermining. Sutures are not to be applied, or used only for the purpose of maintaining the parts in apposition. After hæmostasis is effected the powdered citrate of silver is thinly dusted over the wound. If the parts have been badly contused, or if inflammation has already set in, a water dressing is applied; in other cases the dressing should be dry, as for operative wounds. Care must be taken to secure a quiet and firm position for the affected part. The wound and its immediate neighborhood soon become aseptic, as is seen from the purely serous secretion that appears; and they remain so, for the citrate of silver infiltrates the neighboring tissues and sterilizes, without in any way

irritating them. Local abscesses may be caused at a distance from the wound by disease organisms; they must be treated in the usual way. Plastic and other operations are as a rule done secondarily.

5. TREATMENT OF ULCERS, ABSCESSES, FISTULÆ, SUPPURATING CAVITIES, INFLAMED MUCOSÆ, ETC.

The affected area must be cleansed, as with wounds. Ulcerated surfaces clean up under dustings of the citrate of silver and wet or dry dressings, in a few days. Abscesses that have been opened and suppurating cavities are first irrigated with 1 to 1000-5000 lactate or citrate of silver solutions, and then packed with silver gauze. The deeper layers are to be removed only when granulations have appeared. The mucous membranes bear the silver solutions very well indeed, as also do the serous membranes of the abdominal and the thoracic cavities. The citrate and lactate solutions have at least the same antiseptic value as those of the nitrate of silver, but are not irritating like the latter. Bougies of the citrate of silver may be introduced one to three times a week in chronic fistulæ, and in cavities and sinuses that are difficult of access. Wet applications of the citrate of silver solution, 1 to 4000, to inflamed parts, more especially in inflammations of the eyelids, have all the efficacy of an active but non-irritating antiseptic. At every change of dressing the neighborhood of the wound is to be thoroughly cleansed by means of baths and rinsings with water or with benzine.

A little practice will enable us to entirely avoid the only disadvantage of the silver treatment—the light-brown discolorations of the linen that it occasions. When such do occur, they can readily be removed by immersion for two or three minutes in a solution composed of sublimate 10.0 grm. ($2\frac{1}{2}$ drachms) and ordinary salt 25.0 grm. (1 oz.) to 2000 grm. (2 quarts) of water, followed by a vigorous rinsing.



A Hand-Book of Medical Climatology, Embodying its Principles and Therapeutic Application, with Scientific Data of the Chief Health Resorts of the World. By S. EDWIN SOLLY, M. D., M. R. C. S., late President of the American Climatological Association. In one octavo volume of 470 pages, with engravings and colored plates. Cloth, \$4.00. Lea Brothers & Co., Publishers, Philadelphia and New York, 1897.

The time is ripe for a scientific, practical and authoritative treatise upon this most important subject, which has hitherto never been placed at the command of the profession. Faith in the great curative virtues of climatic

prescriptions is too often shown only *after* the failure of drugs, and perhaps then the change is ordered without full knowledge of essential conditions. Fortunately recent years have seen the virtual completion of governmental and professional observations covering practically the whole of the United States, and giving precise data of a range of resorts affording climates of almost every variety and excellence. European nations have long since recognized the health and wealth-giving value of their climatic resources, and have published full data regarding them. Combining all this information, often in a comparative and tabular form, Dr. Solly has now for the first time furnished the physician with the information necessary to a choice of a climate adapted to a given case. Thirty years of experience and special study have enabled the author to reduce the vast volume of observations to a scientific basis, and to draw therefrom laws affording trustworthy conclusions of practical applicability. The work is therefore one of importance to every physician, since his power for good can be greatly enhanced by adding an accurate knowledge of this science to his therapeutical armamentarium.

Lippincott's Medical Dictionary.—A Complete Vocabulary of the Terms Used in Medicine and the Allied Sciences, with their Pronunciations, Etymology and Signification, Including much Collateral Information of a Descriptive and Encyclopedic Character, Prepared on the Basis of Thomas' Complete Medical Dictionary, by RYLAND W. GREENE, A. B., with the Editorial Collaboration of John Ashhurst, Jr., M. D., LL. D., Barton, Professor of Surgery and Professor of Clinical Surgery in the University of Pennsylvania; Geo. A. Piersol, M. D., Professor of Anatomy in the University of Pennsylvania; Joseph P. Remington, Ph. M., F. C. S., Professor of Theory and Practice of Pharmacy in the Philadelphia College of Pharmacy. Philadelphia: J. B. Lippincott Co.; London: 6 Henrietta Street, Covent Garden; 1897.

The lines followed by Dr. Thomas in his celebrated dictionary have been followed by the able gentlemen whose names appear on the editorial page. Some surprise may be expressed at the announcement of another medical dictionary. The critic will, however, be, in a general way, disappointed in his endeavor to pick flaws in Lippincott's Medical Dictionary.

Its plan is to give complete information concerning every medical term which might have a legitimate claim to inclusion, so as to provide for the most extended needs of the student, physician, and special investigator.

The work is well printed and will become a standard book of reference.

CORRESPONDENCE.

"HIT 'EM ANOTHER LICK!"

A well-known professor in one of the oldest medical schools in the West, says:

"But, while I am explaining why I cannot write anything which you will print, or should print, because I do not care a picayune about the whole business (and I am not doing any free practice, either), I want to also keep you at it if possible. The TRI-STATE was getting less interesting, and I was afraid you had failed to see that you should keep in the field where you have no superior. The most delightful reading in medical journalism are your editorials when you get out with war-paint all over your face. The times are out of joint, and the only way to reduce the dislocation is to hammer them with a spiked club. Hit 'em another lick!

"My training has been such that for the life of me I cannot take seriously to a question of finance as a part of the profession of medicine. But I can talk seriously about the therapeutics of pneumonia, and I have not forgotten my promise to send you an article. It may arrive at any time—it certainly will reach you before the dispensaries close up in St. Louis."

THE ABUSE OF MEDICAL CHARITY—VIEWS OF BEN. H. BRODNAX.

BRODNAX, LA., June 5, 1897.

EDITOR TRI-STATE MEDICAL JOURNAL:

Dear Doctor—The JOURNAL of May in hand. On page 234 you ask: "Are you with us?" Of course, so far as I can aid you in checking what is, to my mind, a *real outrage*. But if I were going to start practice of medicine I would certainly go to a town not large or rich enough to hold a hospital. We backwoods doctors are free of *this* curse at least. We travel two, five or ten miles from home often to see people, when we are physically no better off than those who claim to be very sick; but we do not have *this class of men* to deal with, who form (as I see them) the officers of the "free dispensaries."

The way I look at it from this "neck of woods": Some man who has, by fair or foul means, made a fortune, when he comes to die wishes to be remembered for the good he has done, and to have the evil forgotten endows a "free dispensary," or an addition to a college or hospital, to be called by his or some family name.

The charitable intent of the donor is carried out, and the installed officers are—what? Reports, if they are correct, and your JOURNAL on page 219 being proof of the charge, is that the officers of such institutions are not all of them honorable men. If they were, such abuses would not go on.

Your city is not the only one. I have letters from friends in Eastern cities which say: "The free dispensaries and hospitals are driving the doctors to the wall—poverty stares me in the face. Ten years ago I had a

splendid in and out-of-town practice. To-day my patients that were, come to the city on the cars, bring their friends with them, and are treated free of all charge by the hospitals of our city." A strong article is in the June *N. Y. Medical Times* also.

Doctor, you must get down on the *officers of these institutions*. It was not the intent of the donors that such wholesale *freedom* was to be used. Get the names of these fellows and put them where they will be known in their true characters, *i. e.*: "shysters." They are advertising schemes and a travesty of justice in every respect. They are not carrying out the *will of those who built these charitable institutions*, but using them to advance their own money-making schemes. The sooner the law is shoved on them and honorable men put into their places the better. Your Missouri Board of Health was taught a "healthy" lesson by your courts. Try the same game on these other abuses. And when you do go to work, put men after them who have no fear of anything except that of *not doing their full duty*. It is useless to talk to these men. Just as well whistle tunes to a mile-stone. Put the spade by the side of it and jerk it out. There must be some moral or *legal* enactment that will meet their case.

I read the *JOURNAL* with much pleasure and profit—thanking God that I do not live in a *free dispensary city*.

Yours very truly, BEN. H. BRODNAX.

DOCTOR McKLVEEN IS WITH US.

WAVERLY, IOWA, July 1, 1897.

DR. JAMES MOORES BALL, St. Louis, Mo.:

My Dear Doctor—I have been much interested in the articles appearing in the *TRI-STATE JOURNAL* on the abuses of the free clinic of the cities.

It often happens that cases that from their nature are safely operable upon, all things considered, by the family physician, are induced from reasons of economy to go to some medical center and make a clinic of themselves rather than pay the family physician a reasonable fee.

I know of one case that went to the "city," was operated upon before a class of nine or ten students, was boarded and nursed in the hospital free, was only out for railroad fare, and yet could have paid well for the services, being worth over \$200,000. And now he goes to every one whom he hears needs surgical attendance advising them to do likewise.

What inducement is there for the doctor in the smaller places to keep himself prepared to do his own surgery, if he has to bid against free clinics? If the specialist in the city hopes to maintain his paying country clientele, he must treat the country doctor courteously.

Whenever a case comes to a city clinic, let them ask who are you? Where are you from? And if from the country, who was your family physician? Why have you not a letter from him giving a history of the case—and make them produce one? In it the doctor can give the facts, and, if deserving of charity, say so; and his silence on that point, or a private letter to the specialist, will inform him of the patient's financial condition. I know of one specialist who makes it a practice of finding out the family physician from his out-of-town patients, and then telegraphing him to find out the financial condition, putting the patient off till the next day for complete advice as regards his case.

There is an almost universal prejudice existing among the "country" doctors as regards sending cases to the cities, because so often they come back saying: "Dr. A. was going to charge me \$50.00 to do the job, but I went to the city, had a specialist do it, and it only cost me my board." The effect it has on the laity as regards the home doctor is obvious.

I am glad you have had the backbone to fight this evil, and "we" in the country are with you. May success attend your efforts.

Yours truly, H. B. MCKLVEEN.

"GOD BLESS YOUR JOURNAL."

BISHOPS COLLEGE, MONTREAL, CANADA, July 15, 1897.

TO MANAGER OF TRI-STATE MEDICAL JOURNAL:

Dear Sir:—I beg to announce to you that after my year shall have elapsed, which I believe is up, or near so, I shall cease to be a subscriber. I regret this very much. I will soon depart for Europe, but on my return, or even while there, I may still communicate with you. I wish you good luck. God bless your journal.

Yours truly, JNO. FRANCIS.

ABSTRACTS.

Sunstroke.—How the world slowly imbibes useful knowledge and awakes to the perception of truth. Who thinks of the older remedies for sunstroke, when ice or cold water is obtainable? When a man has a temperature of 112° it is not worth while to wait for the slow action of drugs. The human brain will not long withstand such a temperature, and the only thing capable of reducing it in time to save the delicate cerebral structures from irreparable injury is cold. Ice or cold water should be applied to the head and chest; the body stripped and sluiced with cold water, enemas of ice water given; and the body rubbed with ice.

Far different is the management of the much more common affection, heat exhaustion, when the patient faints from oversweating. Here the pulse is feeble and the temperature may be subnormal. A hypodermic of atropine, strychnine, alcohol or ether, is the speediest remedy, or the handiest stimulant by the mouth. Alcohol, cologne, bay rum, camphor, ammonia, capsicum, ginger, any volatile oil, any of these may be used to restore the patient to consciousness. Mustard or any form of heat is to be applied externally, and hot coffee or other stimulants thrown into the rectum. The head should be lowered and the clothing loosened about the neck and chest.

The after-treatment differs also. It is rare for a man to recover perfectly after true sunstroke. The brain has received a shock that permanently disorders its structure or functions. He should be at once placed where he can be kept cool, and the brain kept at rest as absolutely as possible. A year is not too long a time to allow for restoration; and if this is well-

spent he may be able to resume his occupation. But in many cases it is advisable that he should follow the snow-line north every spring, and never again expose himself to a temperature approaching the nineties.

The pathology of heat exhaustion is traceable to vaso-motor paresis. This allows free sweating and consequent loss of salt, with uncontrollable thirst. Begin at the beginning and seal up the leaky skin by means of small doses of atropine or, better, of hyoscyamine, with brucine. One granule of each should be taken every hour until the physiological effects are manifest, and these are to be kept up all day. Only slight perspiration is to be allowed. Thirst is to be restrained by sucking a lemon, or by holding a bit of lemon-peel or chewing-gum in the mouth. The diet should be highly nutritious, with little fluid and that only after the meals. Overexertion and exposure to the heat must be avoided. The weight can be rapidly reduced by the dry diet, and corresponding comfort secured.—*Alkaloidal Clinic.*

Pyo-Pericardium.—At the St. Louis City Hospital Dr. Otto Sutter recently opened the pericardium for suppurative pericarditis, evacuating fully a quart of pus and removing several large pieces of fibrinous matter. Since the operation there has been decided improvement in the patient and everything indicates a successful termination. Up to April 1, of this year, there had been twenty-six reported operations with sixteen deaths—so the prognosis in pericardotomy for pyo-pericardium may be said to be very good (when compared with 100 per cent. of deaths without operation), these figures giving a percentage of recovery of 35.4. Of the fatal cases at least nine were septic, and all the others who died had complicating lesions, such as pleuritis or pulmonary, cardiac or renal lesions.—*Am. Jl. Surg. and Gyn.*

Operative Gynecology and Insanity.—1. Gynecological operations are more likely than any other surgical procedure to distract the mind. 2. Hereditary antecedents of the patient should always be determined. 3. In insane patients operations should be performed only when the physical condition endangers life or renders it insupportable. 4. Patients, precedent to the operation, should be in a calm frame of mind; hence moral treatment of the patient previous to operating is the best prophylaxis. 5. Inherited and acquired insane constitution is the fundamental factor in most cases of insanity. This conclusion does not, however, justify us in ignoring physical diseases immediately preceding or associated with insanity. 6. Healthy genital organs do not give rise to reflex symptoms; consequently caution should be exercised in operating for the relief of insanity. 7. Operations may be satisfactory in properly regulated cases.—Dr. A. H. McFarland, in the *Cincinnati Lancet-Clinic.*

Constipation in Women.—A very frequent cause of disease in women is constipation. It is remarkable how careless many women are in this respect. It devolves upon the mother to educate the daughter that it is necessary to health that the bowels should move at least once in twenty-four hours. Not only do they have from constipation a poisoning of the system from absorption of the liquid and gaseous contents of the bowels, the ptomaines or poisons developed in them from fermentation producing

depressing effects on the nervous system, with derangement of the stomach and assimilative organs, as shown in pale faces, debility, neuralgia, headache, etc.; but we get, in addition from impaction of the feces in the rectum, uterine displacement, with its consequent disturbances in the pelvic circulation and with its general reflex neuroses. Gynecologists know well that the left ovary is more often diseased than the right one. The left ovarian vein has no valve, and a slight pressure upon it prevents it emptying. Doubtless the pressure of a loaded rectum in this event is a prolific cause of ovarian disease, especially on the left side.—Dr. Holmes, *Southern Medical Journal*.

Heart Disease in Children.—Pott discusses the etiology of heart disease in childhood. Among 30,000 children he found ninety-five cases of heart disease, upon which he bases his conclusions. Acquired heart disease is, in his experience, never primary, but always secondary, to some acute infectious disease, particularly scarlet fever and acute rheumatism, occasionally to pneumonia. In early childhood the rarity of scarlet fever diminishes its importance in the causation of heart disease. The youngest case observed was a boy, aged 3, in whom endocarditis developed in the second week of scarlet fever, leaving permanent mitral regurgitation. Rheumatic fever is the commonest cause in these earlier years, and the statements of other writers who assert the infrequency of rheumatic fever at this age are probably due to the difficulty of diagnosis causing it to be overlooked. Of seventy-eight cases of acute rheumatism with joint symptoms, twenty-one were under the age of two years. A frequent cause of heart disease in children is the so-called masked rheumatism, a vague febrile condition associated with naso-pharyngeal catarrh, enlarged cervical glands, enlarged spleen, herpes labialis and pains in the limbs, sometimes called herpetic fever. These symptoms subside under *sod. salicyl.*, and have sometimes been definitely associated with the onset of endocarditis and pericarditis. Owing, however, to the difficulty of proving their rheumatic origin, the writer has not included such among his rheumatic cases. Congenital heart disease, not including faults of development, may be due in some cases to an attack of acute rheumatism in the mother during pregnancy; one case is quoted in which there seemed to be such a relation. Congenital syphilis in three cases seemed to be the probable cause of the heart lesion. The frequency of acute miliary tuberculosis in children with congenital right-side lesions is noted, and the possibility of intra-uterine tuberculosis as the cause of the heart disease is suggested, though it seems more likely that the tuberculosis is favored by the heart disease.—*Brit. Med. Journal*.

Measles.—To avoid complications, believing such to be due to some external influence causing the eruption to recede or preventing it from appearing, Dr. C. S. Merriman resorts to the hot pack, proceeding in the following manner (*The Kansas City Medical Index*, September):

“Take a flannel binder, wring it out of water as hot as the hand can bear, and wrap patient up in this, with cold cloth on the head. Keep him in the pack about twelve or fifteen minutes; then transfer him to a dry blanket and allow him to cool gradually. This brings the eruption to the surface and relieves the mucous and serous membranes. If necessary, give antipyretics for the fever and sedatives for the cough. I have never had

any complications when I used this line of treatment. When I have a bronchial cough, nothing has served me so well as a combination of terpin hydrate with codeia sulphate made into an emulsion with syrup of acacia.”

The writer lays stress upon the necessity of treating the conjunctivitis in order to prevent trachoma.—*Am. Med. Review.*

Paquin's Serum in Tuberculosis.*—Early in 1895 Dr. Paul Paquin, of St. Louis, reported the results of his treatment of tuberculosis with tubercle antitoxin in the St. Louis Poor House and Hospital. He then began to supply the profession with the remedy. My friend, Dr. C. C. Browning, of Highlan, California, was one of the first, if not the first, in this State to secure a quantity for trial. It was through his kindness that I was able to obtain the serum with which to treat myself.

For the detailed clinical histories of seven of the ten cases treated I would refer you to the *Southern California Practitioner* for October, 1896.

Of the ten cases treated two derived no benefit that was observed. All the others showed symptoms of improvement. The nature of the improvement was manifested by increased appetite, better digestion, gain in weight, increased energy and gain in recuperative power, so that more exercise could be taken without the reaction so peculiar in consumptives; while night-sweats and the cachexia diminished or disappeared. As the toxic poison was relieved, and the resisting power of the body increased, the organism became better able to cope with the invading foe. The bacilli in the sputa diminished in number, while the cough and expectoration was lessened or ceased entirely.

All of the cases that were far advanced or complicated by mixed infection, with two exceptions, improved only for a short time or failed less rapidly. Ordinarily these cases derive sufficient benefit to make them anxious to continue the treatments until a short time before death.

The two exceptional cases that were far advanced had been ill three years and were invalids. One commenced treatment January 6th last and has continued to improve up to the present time. He is still taking the serum and seems in a fair way to get an arrest of the disease. The other began treatment March 25, 1896, and although his improvement has been slow and hindered by adverse circumstances, it has been unmistakable. He writes me from Switzerland that he is still taking serum and that his physician expresses himself as surprised at the gain he is making.

I have no hesitation in saying that from the observation of my own cases and those of other physicians, and from the results reported in this country and Europe, I have come to regard anti-tubercle serum as of more value in the treatment of tuberculosis than any other single therapeutic measure known. It can be employed in connection with any other method of treatment and, indeed, should be aided by every resource known to medicine and at the command of the physician. Recent cases, and those of pure tuberculosis, derive the most benefit. They usually bear large doses—30 to 60 minims—well and respond readily to treatment. But the advanced and apparently hopeless cases are often benefited as by no other remedy.

*Extract from article of Dr. Hoell Tyler, Mentone, California, read before Southern California Medical Society, December 2, 1896. Published in *Southern California Practitioner* for February, 1897.

Conservation in Nasal Surgery.—Dr. Scheppegregell in an editorial in the *Laryngoscope* writes on this subject as follows: The too frequent surgical interference with the nasal turbinates in rhinologic practice of recent years is partially due to a defective knowledge of the pathology of the region involved. The turbinates of the nose are the *locus minoris resistentiæ*; perhaps even the *safety valves* of functional disturbance in many other parts of the body. It is the scape-goat which exhibits the results of unhygienic surroundings, faulty diet, lack of exercise and intemperance and forms a complication in most of the exanthemas and a large number of functional and organic derangements of other organs of the body.

The necessity of proper nasal respiration was impressed upon the rhinologic student, without, however, sufficient importance being laid on the relation of this mucous membrane to other conditions of the body. The most direct method, therefore, of restoring an obstructed respiration appeared to be the removal of the obstruction. Where this is a deviation or thickening of the septum, a tumor or a true hypertrophy, the principle is correct. In the majority of cases, however, the obstruction is simply a passive congestion or hyperæmia, and the removal of this by the electrocautery or other means gave simply temporary results. The same causes which produced the original lesion still existed and caused a prompt return of the obstructed breathing. On account of this rapid return in many cases, a radical measure was at last suggested—turbinectomy—the total removal of one of the important portions of the nasal organ. This operation of course affords a passage for the air; but the total extirpation of the turbinate, while removing an obstruction also removes an important factor required for obtaining the benefits of the operation. The injurious effects are due not only to the loss of so large a portion of the nasal mucosa, which plays so important a role in respiration, but also to the fact that the physical conformation of the nostrils has been altered. The removal of the turbinate increases the caliber of the nostril operated upon, which thus received a larger portion of the respired air; but instead of having its functional capacity increased for this double duty, it has been handicapped by the removal of a considerable portion of the mucous membrane required for this purpose.

This radical measure, however, was not without its good results; it was the signal of the reaction; and now there is hardly a meeting of a prominent laryngological society in which papers advocating greater conservatism in rhinologic practice are not presented. Such articles will stimulate the rhinologist to examine more closely into the pathology of the region involved and will cause him to remember that the nose is not an isolated organ, but forms a part of the complex system, each organ of which is, to a certain extent, dependent upon the other, and that the normal condition of one is dependent upon the normal condition of the remainder. With a true understanding of this principle, the results will be such as to react to the benefit of the patient and to the reputation of the specialist.—*Laryngoscope*.

SELECTION.

Incontinence of Urine.—

℞	Syr. belladonnæ	—
	Syr. tolutani.....	aa 60.0
Mix.	Sig.—Take a coffee-spoonful morning and night.	
Or: ℞	Ferri. carbon.....	0.03 to 0.10
	Extr. Belladonnæ	—
	Extr. nucis vom.....	aa 0.01 to 0.05
Mix.	—Ft. pulv. talcs No. I. (1).	
Sig.	—Begin with one powder daily, and gradually increase the dose until the physiological effect of the belladonnæ is obtained.	

—*Centralb. f. d. Gesam. Theraphie, 1897, xv., 59.*

Alleged Discovery of the Yellow Fever Microbe.—A Roman correspondent of the *British Medical Journal* states that there is no doubt that Dr. Saranelli has achieved this important discovery, and that it is his purpose to publicly announce the fact in one of the Italian journals within the next few weeks. Dr. Saranelli is one of the most accomplished bacteriologists known to the profession. He is thirty-five years of age. His opportunities have been exceptionally fine. A graduate at Siena, he continued his studies in experimental hygiene under Celli at Rome, Roux in Paris, and Behring in Berlin. In 1893 he received the appointment as Director of the Institute of Hygiene of Montevideo. During the summer of 1896 he went to the island of Flores, where yellow fever was severely prevalent. There he performed a large number of necropsies, and was himself smitten with the disease. As soon as he recovered he resumed his investigations at Rio Janeiro, where the disease was raging. Here, at the end of two months of assiduous labor, his effort was rewarded. For some time he was loth to give publicity to the fact that the specific microbe had been discovered. But at length he became so well convinced that he had in hand the yellow fever microbe that he commenced in August last the preparation of the serum cultures. He encountered many obstacles, but these were finally overcome, and he was able to state that "the microbe of yellow fever now splendidly presents itself, and is the strangest of all the microbes that are known."

In order that he might control the knowledge of his discovery he vaccinated over two thousand various animals with his own hand. The results were so assuring that in October last he announced to the President of the Republic of Uruguay, in confidence, the results with which his labors had been crowned.

If his statements shall be verified and his remedy shall prove efficacious in the control of yellow fever, he will be entitled to the reward of 150,000 scudi (\$150,000) which the Brazilian government has offered for the discovery of such a remedy.—*N. Amer. Prac.*, March, 1897.



Resigned.—In order to have more time to devote to his increasing private practice, Dr. Arthur E. Mink has resigned the Professorship of Mental and Nervous Diseases in the St. Louis College of Physicians and Surgeons.

Appointed.—Dr. John B. Hamilton, editor of the *Journal of the American Medical Association*, has been appointed Superintendent of the Illinois Northern Hospital at Elgin.

Iowa State Medical Society.—The officers elected at the last meeting were: President, Dr. Edward Hornibrook, Cherokee; First Vice-President, Dr. H. L. Getz, Marshalltown; Second Vice-President, Dr. J. R. Guthrie, Dubuque; Secretary, Dr. James W. Cokenower, Des Moines; Assistant Secretary, Dr. M. N. Voldeng, Des Moines; Treasurer, Dr. George R. Skinner, Cedar Rapids; Trustees, Dr. S. E. Robinson, West Union, and Dr. D. W. Crouse, Waterloo.

Chicago Medical Society.—The officers chosen for the ensuing year are: President, Dr. Fernand Henrotin; First Vice-President, Dr. A. D. Bevan; Second Vice-President, Dr. J. C. Hoag; Secretary, Dr. A. R. Edwards; Treasurer, Dr. A. R. Reynolds.

Western Ophthalmological, Otological, Laryngological and Rhinological Association.—At a recent meeting of the Western Ophthalmological, Otological, Laryngological and Rhinological Association, held in St. Louis, the following officers were elected: President, Dr. B. E. Fryer, Kansas City, Mo.; First Vice-President, Dr. J. Elliot Colburn, Chicago, Ill.; Second Vice-President, Dr. F. M. Rumbold, St. Louis, Mo.; Third Vice-President, Dr. A. E. Bulson, Jr., Fort Wayne, Ind.; Secretary, Dr. Hal Foster, Kansas City, Mo.; Treasurer, Dr. W. L. Dayton, Lincoln, Neb. The next annual meeting will be held in Chicago, Ill., April 7-8, 1898.

North Missouri Medical Association.—The recent meeting of the North Missouri Medical Association, held at Moberly, Mo., June 17th and 18th, was a pronounced success. A program of scientific papers was presented. The new officers elected are: President, Dr. Robt. Haley, Brookfield; First Vice-President, Dr. J. D. Brummel, Salisbury; Second Vice-President, Dr. C. Clapp, Moberly; Treasurer, Dr. J. F. Welch, Salisbury; Recording Secretary, Dr. Geo. N. Lantz, Brookfield; Corresponding Secretary, Dr. G. O. Cuppage, Moberly.

Died.—Dr. Joel W. Smith, of Charles City, Iowa, died June 6, 1897, at the age of 72. Doctor Smith was a prominent member of the Iowa State Medical Society and a successful practitioner.

Eastern Iowa District Medical Association.—The annual meeting was held at Washington, Iowa, Thursday, June 24, 1897. Officers: Dr. J. W. Holiday, President, Burlington; Dr. Calvin Snook, Vice-President, Fairfield; Dr. M. C. Carpenter, Secretary, Fairfield; Dr. J. H. Hull, Chairman Committee on Arrangements, Washington.

Sioux Valley Medical Association.—The second annual meeting of the Sioux Valley Medical Association was held at Rock Rapids, Iowa, June 16, 1897. Officers: President, Dr. S. A. Brown, Sioux Falls, S. D.; Vice-President, Dr. J. A. Sherman, Cherokee; Treasurer, Dr. G. G. Cottam, Rock Rapids; Secretary, Dr. J. N. Warren, Sioux City. Dr. J. A. Sherman, of Cherokee, was elected President. Next meeting will be held in Sioux City in January.

Medical Picnic.—The second annual picnic of the Decatur County Medical Association was held at the Park in Davis City, Iowa, Thursday and Friday, June 17 and 18, 1897. Officers of the society: President, Dr. A. Brown, Leon; Vice-President, Dr. J. W. Wailes, Davis City; Secretary, Dr. F. A. Bowman, Leon; Treasurer, Dr. B. R. McAllister, Leon. Many interesting papers were read.

Editorial Appointment.—Dr. J. E. Summers, of Omaha, has been added to the staff of *The Iowa Medical Journal*; its value is thereby materially enhanced. Dr. Summers is one of the most brilliant young surgeons in the west. He has been Professor Principles and Practice of Surgery, and Clinical Surgery, in the Omaha Medical College, for ten years; is Surgeon-in-Chief Clarkson Memorial Hospital, Attending Surgeon Douglas County Hospital, formerly Surgeon-in-Chief Immanuel Hospital, ex-President Nebraska State Medical Society, Western Surgical and Gynæcological Association, Omaha Medical Society, etc., etc.

Elected.—The Fremont County (Iowa) Medical Association met at Sidney and elected Dr. T. C. Cole, of Thurman, President, and S. B. Ambler and C. E. Hoöver, Vice-Presidents; Dr. E. F. Cowger, of Riverton, Secretary, and Dr. J. H. Cole, of Thurman, Treasurer.

Northeastern Iowa Association.—The Northeastern Iowa Medical Association held its semi-annual session at Waukon. The following officers were elected: President, C. H. Flynn, Postville; Vice-President, Dr. Berry, Clermont; Secretary and Treasurer, Dr. Brown, Monona. The next meeting will be held at Calmar.

Central District Association.—The Central District (Iowa) Medical Association met at Boone, June 15. These officers were elected: President, Dr. A. Richmond, Ames; Vice-President, Dr. A. M. Pond, Webster City; Secretary and Treasurer, Dr. G. H. Stanger, Boone. This resolution was passed: "*Resolved*, That it shall be deemed cause for expulsion or bar to admission for any member of this society to hold counsel with any irregular practitioners of medicine."

Extensively Circulated.—The Report on the Abuse of Medical Charity in St. Louis is in great demand. Already enough journals have promised to reprint it to bring the circulation above 30,000 copies.

Piatt Co. (Ill.) Society.—The Piatt County Medical Society has been organized at Monticello with Dr. J. W. Coleman, President, and Dr. C. E. Wilkinson, Secretary.

St. Charles Co. (Mo.) Society.—The St. Charles Medical Society has elected as officers: Dr. J. R. Mudd, President; Dr. Wm. Talley, Vice-President; Dr. J. T. Evans, Secretary; Dr. Bruere, Treasurer.

LaSalle Co. (Ill.) Society.—The new officers of the LaSalle County Medical Society are: T. W. Burrows, President; Geo. A. Dicus, Vice-Pres-

ident; E. W. Weis, Secretary and Treasurer; W. H. Frazier, K. W. Leland, E. P. Cook, Board of Censors.

Grand River (Mo.) Society.—The Grand River Medical Society held its annual meeting at Chillicothe, June 4. The new officers are: Dr. Arthur K. Simpson, of Chillicothe, President; Dr. E. Van Note, of Hamilton, Vice-President; Dr. F. W. Burke, of Laclede, Secretary; Dr. B. R. Barney, Sr., Chillicothe, Treasurer. The next meeting will be held at Hamilton, December 2.

Lafayette Co. (Mo.) Society.—The Lafayette County Medical Society has elected as officers: President, Dr. J. H. Straughn, Lexington; Vice-Presidents, Dr. Lewis Carthrae, Corder; Dr. W. G. Harwood, Dover; and Dr. J. J. Fulkerson, Higginsville; Secretary, Dr. W. A. Braecklein, Higginsville.

Dr. Milo B. Ward.—This well-known gynæcological surgeon has removed from Topeka, Kansas, to Kansas City, Mo., where he is located in the Rialto Building. We wish the Doctor much success in his new field.

Military Tract Medical Association.—The next annual meeting will be held in Galesburg, Ill., October 21st and 22d. The officers are: President, Dr. C. B. Horrell, Colchester; 1st Vice-President, Dr. E. S. Mitchell, Roseville; 2d Vice-President, Dr. M. S. Marcy, Peoria; Secretary-Treasurer, Dr. O. B. Wiel, Peoria.

Arrived.—Dr. John C. Morfit, of Baltimore, has arrived in St. Louis, and will make this city his home. He is located in the Chemical Building.

Resigned.—Dr. Charles H. Hughes has resigned from the staff of the Missouri Baptist Sanitarium.

Killed.—Dr. L. A. Berger, of Kansas City, was killed on July 8th by a man who claims to have been wronged. The deceased was Professor of Obstetrics in the University Medical College and was an honored member of many scientific societies.

Dr. G. Walter Barr.—Dr. Barr has removed from Quincy, Ill., to Keokuk, Iowa, where he holds the Chair of Materia Medica in the College of Physicians and Surgeons.

Removed.—Dr. James Stewart has removed from Marthasville to Holstein, Mo.

Missouri Medical League.—The Missouri Medical League of St. Louis was organized July 7th, and elected the following officers: R. M. Funkhouser, President; P. D. Connolly, Vice-President; W. V. Loftus, Treasurer; H. Wheeler Bond, Recording Secretary; Frank G. Nifong, Corresponding Secretary.

Dubuque Medical Society.—The ninth annual meeting of the Dubuque Medical Society was held at Dubuque, Iowa, June 30th, concluding with a banquet in the evening. Dr. Henrotin, of Chicago, demonstrated a case of tumor at Finley Hospital. Papers were read by Dr. Henrotin, of Chicago; Dr. E. A. Ainsworth, of West Union, Iowa; Dr. H. A. Jencks, of Galena; Dr. I. S. Bigelow, of Dubuque; Dr. C. M. Hobby, of Iowa City; Dr. J. C. Lewis, of Dubuque; Dr. W. Hartford, of Cassville, Wis.; Dr. F. W. Wieland, of Dubuque.

FORMULAE.

Follicular Pharyngitis.—To be used as an application by means of cotton applicator for chronic follicular pharyngitis, post nasal catarrh, and atrophic rhinitis:

- ℞ Iodin. pur., gr. iij.
Potass. iodid., gr. v.
Acid trichloracetic, gr. vij.
Glycerine,
Aq. dest., aa ʒ ss.

M. This can be used in varying strengths according to the nature of the case.—*Clinical Chronicle.*

The Creosote Treatment with Children.—Hock (*Wiener Med. Blat.*; *Centralbl. fuer Innere Med.*) uses creosote not only in tuberculosis but also for persistent catarrhal phenomena after measles and whooping-cough, according to the following prescription:

- ℞ Creosote, gr. xv.
Cod liver oil, ʒ iij.
Sacch., gr. ʒ₄.

M. From two teaspoonfuls to three tablespoonfuls to be taken daily.—*Ex.*

Stomatitis in Small Children.—

- ℞ Potass. chlorat., ʒ j.
Tinct. myrrh., gtt. xx.
Elix. calisayæ, ʒ iij.

M. Sig. Teaspoonful in water every four hours.

This prescription should not be used if there is present a condition of acute nephritis.—*Hare, Ex.*

Uric Acid Diathesis.—Dr. N. A. Olive, of Waco, Texas, says in the *Texas Medical Journal* that the following has been useful in his practice:

- ℞ Acid. salicylic., ʒ iij.
Potass. acet., ʒ v.
Aq. dest., q. s., ʒ iv.

M. Ft. sol. Sig. Take a teaspoonful in water every four hours.—*Med. World.*

Hemorrhage.—An able surgeon never fears *hemorrhage* from an open wound. It is in them a frank enemy. Concealed hemorrhage is the thief that comes in the night. In large dissections ligate the larger central vessels in the wound, so far as possible, and many bleeding points may be checked by a single ligation.—*Keen.*

The Prevention of Iodism in the Use of Potassium Iodide.—Spencer (*Journal de Médecine de Paris*) is credited with the following formula:

- ℞ Potass. iodide, parts xxx.
Ammon. ferrocitrate, parts iv.
Tinct. of nux vom., parts viij.
Aq. dest., parts xxx.
Tinct. of cinchona, enough to make, parts 120.

M. Sig. A teaspoonful, in half a glass of water, to be taken after each meal. The tincture of nux vomica and the ammoniocitrate of iron are said to check the tendency of coryza and at the same time to act as tonics.—*The Prescription.*

A Painless Blister.—The following formula is given in *La Médecine Moderne*:

- ℞ Menthol,
Chloral hydrat., aa gr. xx.
Ol. theobromat., ʒ ss.
Spermaceti, ʒ j.

M. Ft. pasta.—*Med. Bulletin.*

Colorless Iodine Ointment.—

- ℞ Iodi, gr. xx.
Potass. iodid., gr. iv.
Sodii sulph., gr. xl.
Aq., q. s.

Rub the chemicals with the water until the solution becomes colorless. Then add:

- ℞ Adipis benzoati, ʒ j.

M.—*Med. Rec.*; *Atlanta Clin.*

Epitheliomata of Slight Extent.—

℞ Resorcin, ʒ ss.
Potass. chlor., ʒ iiss.
Aq. dest., ʒ x.

M. Sig. Apply frequently as a wash.—*Brocq. Dom. Med. Mon.*

Obstinate Nose-Bleed.—In refractory cases of epistaxis Rougier tampons the posterior nares with cotton impregnated with:

℞ Benzoic acid,
Tannic acid,
Carbolic acid, aa gr. xxv.
Flexible collodion, ʒ j.

M.—*Western Druggist.*

The Horsechestnut as a Remedy

for Hemorrhoids.—Artault, in *Revue de Therapeutique*, acting on the hint of the popular esteem in which the horsechestnut is held as a remedy for hemorrhoids, has used a concentrated tincture of the nut in twenty-one cases, and always with very striking results. He thinks it acts as a specific on the pain and has a direct and intense constrictive action on the veins of the pelvis. He gives ten drops of the tincture once a day, and finds that usually a few days' employment of the remedy is sufficient.

About Pessaries.—There is an impression among many students, and even with some practitioners, that a pessary is introduced to reduce a displacement of the uterus. This is a serious mistake. A pessary is only to retain in place, by a pulley-like action on the wall of the vagina, the replaced uterus. If a pessary be introduced while the uterus is retroverted, it tends to render the condition worse by converting it into retroflexion—the fundus bending over the posterior bar of the pessary.—*Montgomery.*

Eggs in Therapeutics.—The *Medical Record* gives the following ways of using eggs in therapeutics: A mustard plaster made with the white of an egg will not leave a blister.

A raw egg taken immediately will carry down a fish-bone that cannot be gotten up from the throat.

The white skin that lines the shell of an egg is a useful application for a boil.

White of egg beaten with loaf sugar and lemon relieves hoarseness—a teaspoonful taken once an hour.

An egg added to the morning cup of coffee makes a good tonic.

A raw egg with the yolk unbroken in a glass of wine is good for convalescents.

Convulsions in Children.—Simon gives purgatives after the following formula:

℞ Sod. sulfur, 10.0
Sennæ fol. pulv., 8.0
Mel. commune, 21.0
Aqua distill., 150.0

M.

In children under two years of age enemata containing 10 grm. of Glauber salts in a mixture of olive oil and glycerin in 150 grm. of water, are to be administered. Simon also recommends the inhalation of ether, the use of mustard baths and internally, bromide of potassium and ether in sugar water.—*Jour. de med.*, 1896, 16.

Treatment of Favus.—Pirogoff's ointment:

℞ Potas. carbon., 8.0
Flor. sulphur, 30.0
Tinct. iodi.
Picis liquid, aa 100.0
Adipis, 200.0

M. Ft. ungt.

The sulphur and tar in the ointment act as antiparasitics, the iodine removes the hairs, so that epilation is unnecessary. The ointment is to be spread on lint, of the thickness of a knife-edge, and renewed daily. After the ointment has been used for a few days, a slight dermatitis is developed, which may be treated with Lassars' paste. The time of cure of favus in this manner is usually eighteen days.—*Pediatrics.*

PUBLISHER'S DESK.

Sanmetto in Bright's Disease.—Charles F. Reiff, M. D., of Fremont, Ohio, says: "I prescribed sanmetto in a case of advanced Bright's disease. The patient became more comfortable, and since then has used several bottles of sanmetto. In my opinion sanmetto is the most efficient remedy for diseases of the genito-urinary organs, and I shall continue to prescribe the remedy."

Premature Labor With Hemorrhage.—I had a most excellent case on which to try sanmetto. It was that of a woman about 40 years of age, who had a premature labor followed by a terrible hemorrhage. She bled about two hours before I was called, and when getting there I found a pale-looking form of a woman which had fainted away twice from loss of blood. I gave her two teaspoonfuls of sanmetto and the hemorrhage ceased in about five minutes. She rested quietly for about one-half hour when she took to coughing, then the hemorrhage commenced again. I gave her another large dose of sanmetto and it stopped again. I stayed with patient about three hours and no more hemorrhage occurred, and so I went home leaving no medicine except the part of the bottle of sanmetto, advising the attendants to give it as directed if hemorrhage should occur again, but it did not occur again and the woman is improving nicely now whereas at first I thought it a hopeless case. I do believe that it was the sanmetto that saved her. I have also used sanmetto a couple of times previous to this case in combination with ergot, and the effect was all right then also.

WM. B. STOKER, M. D.

Lancaster, Iowa.

Imperial Granum.—The following letter, just received by the Imperial Granum Company from the publisher of one of the most influential of American medical journals, must certainly be most satisfactory to the manufacturers of that sterling food preparation:

"Beginning with the grip, I ended up with a severe attack of gastric fever. This gave me an excellent opportunity to test imperial granum, and I assure you it was a great pleasure to have something that was at once so pleasant to the taste, so nourishing, and so grateful to a delicate stomach. After being compelled to abstain from food for three or four days, I partook of the imperial granum quite freely, without the least disturbance of the stomach. As we have had much experience in dealing with delicate and sensitive stomachs, we thought it very remarkable that any food should prove so nourishing and yet could be taken so freely under such circumstances. I was glad to have such an opportunity to test your food, and I shall always be glad to recommend it."

Eureka Springs, Northwest Arkansas.—This famous health and pleasure resort is located in the heart of Ozark Mountains. Climate mild and bracing. Scenery wild and beautiful. Waters unequalled for purity and medicinal qualities. The Crescent Hotel is now open. Rates reasonable.

Excursion tickets on sale all the year. Through sleepers via St. L. & S. F. R. R. Write to Geo. T. Nicholson, G. P. A., Frisco Line, St. Louis, Mo., or Manager Crescent Hotel, Eureka Springs, for descriptive pamphlet.

Treatment of Sample Fiends.—The following letter shows how one company at least is shutting off "self-prescribing":

OFFICE OF THE IMPERIAL GRANUM CO.
NEW HAVEN, CONN.

Dear Sir (or Madam): We acknowledge the receipt of and thank you for your request, and are sorry to have to say that we cannot comply with it—owing to the fact that we supply samples of the Imperial Granum to physicians, or to whom they may direct (and to professional nurses), only, realizing that the physician alone can determine the diet that each individual case may require. If desired by your family physician we shall be very glad to send you a physician's sample box of the Imperial Granum.

Very respectfully, THE IMPERIAL GRANUM CO.

New Medical Dictionary.—Warner's Pocket Medical Dictionary of To-Day. By William R. Warner. Copyright: William R. Warner & Co., Philadelphia. 1897. Large 16mo. Pp. 338. Cloth. This book contains 304 pages of dictionary material, comprising the "pronunciation and definition of 10,000 essential words and terms used in medicine and associated sciences." The preface claims that "diphthongs have been omitted except in instances when the plural of a word is intended," but in it may be found words like "anemia," "edema" and "uremia" spelled with the diphthong. In purposely omitting many very common medical words and terms, "because their definitions are so well known as to obviate the necessity of their classification," so much space has been gained that the volume is sufficiently small to allow carrying conveniently in the pocket. It is a useful book from which to get an idea as to the meaning and pronunciation of most medical words.

Prize Winners.—*Dear Doctor:* The articles received by us for competition under our recent prize offer were turned over to a committee of prominent physicians, consisting of T. C. Gilchrist, M. D., Associate Professor Dermatology, Johns Hopkins University; Wm. F. Smith, M. D., Professor Dermatology, College of Physicians and Surgeons, and Edwin Geer, M. D., Surgeon Maryland Naval Reserves, for examination and report as soon after May 15th as practicable; and the committee having completed its work, we have now to announce the following awards:

First prize, \$100.00, to Dr. Walter P. Ellis, Livermore, Ky.

Second prize, \$60.00, to Dr. J. Hobart Egbert, Holyoke, Mass.

Third prize, \$75.00, to Dr. J. M. Rader, St. Louis, Mo.

Fourth prize, \$40.00, to Dr. E. A. Edlen, Moline, Ill.

Fifth prize, \$50.00, to Dr. Ed. C. Hill, Denver, Col.

Sixth prize, \$25.00, to Dr. J. Grant Coyle, New York, N. Y.

We would add that the names of the contestants were withheld from the committee, in order that its decisions might be entirely unprejudiced.

Very respectfully,
RESINOL CHEMICAL CO.
Baltimore, Md., June 14th, 1897.

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., AUGUST, 1897.

No. 8.

ORIGINAL ARTICLES.

TREATMENT OF INTRA-CAPSULAR FRACTURES OF THE FEMUR, AND HIP-JOINT DISEASES.

By T. J. MAXWELL, M. D., of Keokuk, Iowa.

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IT seems like presumption for me to attempt to say anything upon the subject of intra-capsular fractures of the femur that has not already been much better said. This subject has engaged the attention of the best minds of the profession, until we would think that every phase of it had been thoroughly elucidated.

Intra-capsular fractures of the femur are fractures which involve the neck of the femur, and fall entirely within the insertion of the capsule of the joint. They are peculiar to advanced life, and occur most frequently in females. The fractures are remarkable in two respects: First, for the trifling amount of force sometimes necessary for their production; second, for their failure to unite by bony matter.

Remarkable changes take place in nutrition of the head and neck of the femur in old persons. The shape is changed, the size altered, and the structure modified. The neck joins the shaft more nearly at a right angle; the neck diminishes in size and becomes more fragile, on account of the cells of the sponge tissue becoming more rarified and filled with fat.

The possibility of bony union in these fractures has been discussed with no little warmth at various times. The careful investigations of Sir Astley Cooper and the searching analysis of Hamilton are quite sufficient to show that bony union, while it is possible under certain favorable conditions, such as an unbroken periosteum or, according to Bigelow, an impaction, is so exceedingly rare as in no way to invalidate the truth of the general law of non-union.

Why does union not take place? For various reasons: First, defective vascularity; the vessels which supply the head of the bone enter its substance through the ligamentum teres and the reflected portion of the capsular ligament, and when fractures take place it must depend entirely for its vitality upon the arterial branch which ascends the round ligament, a supply barely sufficient for its own existence and sometimes not equal to that; and, second, whatever reparative material may be deposited has no local permanence—that is, there are no interlacing threads of connective tissue about the fracture which can serve as a *nidus* for its reception and support while passing through the stages of development. Third, any reparative material furnished by the vessels becomes so diluted by intermixture with the increased synovial fluid as to be incapable of progressive organization. Fourth, mal-adjustment of the fragment or imperfect coaptation and inability to maintain that perfect quietude so necessary to the repair of these injuries also militate against union. These causes, together with the action of numerous powerful muscles which have their attachment near the fracture, and which are disposed about the joint in the most favorable directions for disturbing the lower fragments, constitute the chief reasons for non-union.

The above is largely taken from Agnew's "Surgery," and we still quote from him, as he represents all that is taught in modern surgery as to treatment. He says: "The treatment of intra-capsular fractures has formed the subject of considerable difference of opinion. With Sir Astley Cooper it consisted in simply supporting the limb, moderately fixed on a kind of double-inclined plane made of pillows, and after the immediate effects of the accident were passed (say from twelve to fifteen days), directing the patient to sit up and as soon as possible to begin to move about on crutches."

Mr. Erichsen advised a similar plan of treatment, and some American surgeons recommended the same course. Agnew says: "I do not, however, think that this practice is very largely adopted by the profession on this side of the Atlantic, and there are strong reasons, in my judgment, why it should not be. There have been recorded a sufficient number of bony unions after what were believed to be intra-capsular fractures to justify a hope that some of the cases encountered by the surgeon may have a similar termination.

There is cause to assume that in these favorable cases the lesion was partly external to the joint, and hence the osseous consolidation which followed; yet, the very uncertainty on this point in any given instance of articular fracture is sufficient reason for the plan of treatment advised.

Agnew says: "I adopt the rule of treating every fracture of the femur (except that of the upper third) as though it were situated in the shaft of the bone, by placing the patient on the back on the bed with the foot elevated, and making extension by means of adhesive plasters, attached to a cord running over a pulley with weights, and supporting the sides of the

limb by sand bags." It is impossible to prove union in any particular case so long as this vicious circle of denial is adopted, that in case of union there must have been fracture within and without the capsule. It is the same old ordeal that determined the guilt or innocence of those who were formerly accused of witchcraft and doomed to destruction.

The failure on the part of the surgeon to devise adequate means to maintain the fragments in these fractures in coaptation is enough to account for a great many failures of union. Those cases that suffer fracture from very slight causes, showing degeneracy of structure, perhaps would not unite under any circumstances. But a very large per centum of fractures of the hip in persons over fifty occur in healthy, well-nourished persons, and are caused by force sufficient to break a healthy bone. There is no evidence other than the simple fact that the person is over fifty and has an intra-capsular fracture that there is degeneracy.

Now, if surgery treated fractures in the shaft of bones no more efficiently than is proposed for the hip-joint, there would be almost an equal number of failures to unite, and we might be reduced to the necessity of accounting for non-union by shifting the responsibility off on nature—lack of nutrition and degeneracy of bone.

What is there about a fracture partly within and partly without the capsule that would make it any more likely to unite? Is the fragment in the joint any better supplied with nutrition on account of it—would not the joint water dilute the plastic material and defeat the efforts at union?

I ask the profession to consider calmly if there is not too much prominence given to degeneracy of bone and lack of vital energy and not enough to failure to keep the fragments in coaptation. It is a cardinal principle in the treatment of all fractures that the fragments must be maintained in coaptation. Extension, counter-extension to overcome the contraction of muscles (which are the displacing forces), splints, compresses and bandages are the means used to attain the end.

Extension must always be used in an opposite direction to the displacing force.

In the case of intra-capsular fracture let us examine the tendency to displacement and the forces operating to produce them. All the forces operate on the lower fragment, and upon it only. The tendencies to displacements are two: namely, upward and inward. The muscles that are involved in this double displacement are numerous and strong. Most of them, during contraction, have a tendency to draw the femur up, shortening the limbs; at the same time they rotate the leg outward and draw the trochanter powerfully toward the pelvic bones—generally behind the acetabulum. In complete fracture of the neck we have some shortening, as a rule, generally eversion of the foot and flattening of the hip. The trochanter is not as prominent as that of the well side. And this is true though the leg be extended to its normal length. Crepitation may generally be produced by extending the leg and rotating while in extension. Where we have the above symptoms clearly developed in a patient seventy-two years old, with the admitted proneness to fracture of the neck increasing with each year over fifty (Sir A. Cooper), is it exactly logical to say, in case of union, that it was something different, that it was not an intra-capsular fracture, but was partly within and partly without the capsule?

The teachings of modern surgery in these cases is to use extension, and hope the inward displacement may, by the same means be corrected, and that it may be after all partly within and partly without. If this is not sufficient, what shall we do for these fractures?

In answer we submit the following plan, which we claim is rational, and has proved successful in five instances in our practice, which at least should secure for it a fair trial, as any mode of treatment that promises to secure better results in these unfortunate and distressing cases ought to be received with favor and be honestly tested as to its claims and value. If I can but provoke such a test for the plan, I shall be perfectly satisfied to let it stand or fall on its merits or demerits.

The plan proposed is as follows: To apply extension in two directions, in opposition to the displacing forces, longitudinally and laterally. Longitudinal extension is applied in the usual way, by adhesive straps running along the sides of the thigh and leg beyond the foot, to which the weight is suspended. Lateral extension is applied by passing a strip of muslin five inches wide around the thigh as closely to the body as possible, the patient being on his back. A splint should be adjusted to the inner aspect of the thigh (Ahl's porous splint answers well), to keep the lateral extending band from cutting. The pulley at the side should be placed opposite the crest of the ilium and about four inches above, so that the lateral extension will act, as relates to the body outward, slightly forward and upward. Counter-extension is secured by making the body perform the duty. The bed is elevated at the foot, the side corresponding to the fracture one foot, the other eight inches; the head-post on the fracture side (the side on which the pulley is attached), four inches. In case of fracture of the right thigh the body will gravitate toward the left-hand head-post, being in opposition to the two extending forces. In this way we bring the two fragments as nearly and as accurately in coaptation as we can in any other fracture of the femur, and they are as easily maintained in that position; the rough and jagged surface of the fractured neck is carried away from the inner surface of the capsule and ceases to fret and irritate it, thereby to a large extent removing the cause of inflammation of the joint, which is an important factor in the causes that defeat union. The inner surface of the capsular ligament, rendered tense by lateral extension, is made to apply itself closely to the sides of the neck, and in that way give support to the plastic callus.

Weight sufficient for longitudinal extension (about fourteen pounds) should be applied. The leg brought down to its normal length, as determined by measurement and comparison with the uninjured one. A steady pull on the side-extension band will soon bring the hip to its proper fullness. By comparison it will be quite easy to determine when the trochanter is as prominent as the well one. Eight or nine pounds will maintain it in that position until the irritability of the muscles subside, when both weights may be gradually diminished to one-half or less. The fracture dressed in this way gives ease and comfort to the patient that simple longitudinal extension could not give. There need be no trap in the bed for the purpose of evacuating the bowels, as a sufficient motion of the body can be tolerated, without fear of displacement, to allow the use of an ordinary bed-pan. Danger from bed-sores is almost nil. Pain and soreness in the in-

jured hip soon subside, and after the first two days the patient gets along without opiates. The following cases were treated by this method:

Mrs. G., aged 52, fell on her right hip, January 14, 1871, and fractured the neck of the femur within the capsule. There were all of the symptoms of intra-capsular fracture: hip sunken, foot everted, limb shortened and crepitation on extension and rotation.

The lady being thin in flesh gave an excellent opportunity to make a diagnosis by comparison with the sound side. I first dressed the fracture according to "regulation," by simple longitudinal extension by means of Day's splints, but observed that the hip was flat, though the limb was extended to its normal length, the trochanter lay behind the acetabulum and was painful until brought into position by a change of dressing, which was done in about ten days, substituting extension, longitudinal and lateral, as has been described. The patient expressed great relief as soon as the lateral extension was applied, and suffered no more from pain in the hip during the balance of the treatment, which was continued about seven weeks longer. At the end of that time union seemed to be perfect. Callus could be felt swelling out before and behind the trochanter. I could discover no shortening by careful measurement. This case was reported some years since in a paper read before the Military Tract Medical Association, and published in the *Chicago Medical Examiner*. This lady is still living. She is now sixty-eight—sixteen years after the fracture occurred.

She is able to attend to all the household duties of a farmer's wife. Had simple extension been continued in this case, there is no doubt in my mind that the result would have been non-union, shortening of the limb and the lady a cripple for life. It would then have been another instance of intra-capsular fracture with non-union on account of degeneracy of bone and lack of nutrition in the head.

But I suppose it will be classed with those fortunate cases where a fracture, partly without and partly within, has been mistaken for intra-capsular fracture. So let it be, and we will proceed to relate another, in all respects similar, except the age.

Mr. R. P., aged 72 years, fell from a lumber wagon the 29th day of January, 1881, striking upon the right hip. Found him a short time after the accident lying on his back on a bed, right leg shortened about an inch, foot completely everted; complained of great pain on the least attempt at movement of the hip. The hip was flat, the trochanter appeared to be behind and above the acetabulum. Under chloroform crepitus was developed by extension and rotation.

Longitudinal and lateral extension was applied, as described. The old gentleman was kept upon his bed just seven weeks, when all dressings were removed. Union had taken place at the end of five weeks, but as a precautionary measure we continued the treatment two weeks longer. Soreness passed away at the end of a week, so that I could press all around the trochanter without producing pain.

He took two powders of morphine two nights following the accident. During the whole of his treatment, to the surprise of himself and friends, he suffered scarcely any pain, and after the first week slept soundly, and his appetite remained good throughout. I could discover no shortening

by careful measurement and comparison with the well side. I am perfectly well satisfied that this case, too, would have not united without lateral extension. This treatment is easily applied, is comfortable when applied, is rational, for it fulfills the indications which longitudinal extension alone does not. Is equally indicated whether the fracture is wholly within the capsule or partly within and partly without. Has succeeded in securing efficient union (whether osseous or not, I do not pretend to say) in three cases in which longitudinal extension alone would have failed.

CASE 3.—Mrs. Courtney, an Irish woman, 64 years old, in indigent circumstances, poorly clad and fed, and living by an open sewer under the worst kind of sanitary conditions, in a miserable shanty, in January, 1883, fell upon her left hip. Six days after the injury she was lying on a bed, saturated with excreta, suffering extreme pain from the swollen and inflamed hip. She could not bear to move and would scream with pain at the slightest attempt to handle the limb. Under an anæsthetic she was removed to a table and an intra-capsular fracture of the left femur diagnosed. A bed-sore had already formed from lying in one position so long in a bed soaked with urine.

I extemporized a bed as best I could from the materials at hand; elevated the foot and side as has been described. The extension in the two last cases was made by applying the adhesive straps to the thigh alone, thereby giving freedom to the knee-joint and passive motion, and prevented swelling and temporary partial stiffening which followed the long extension on the first case. The lateral extension at the side of the bed as in the others.

The patient was returned to bed and the appliances all adjusted under the influence of the anæsthetic. She rested well all the night following the applications—the first since the injury. The bed-pan was used from that time on as often as was necessary, and on the second day she was raised to a sitting posture without pain or complaint, all tenderness and most of the swelling having subsided. This was done every day in order to dress the large slough on the sacrum already formed, which healed kindly during the treatment. Callus around the fracture within the capsule formed in two weeks, determined by examination, as the thumb before and the finger behind trochanter readily grasped the neck within the capsule, which was easily done, as the patient was of a thin spare habit.

The case progressed as favorably as any other fracture of the thigh, and in four weeks from the date of application of dressing, five from that of fracture, the dressing was removed, resulting in perfect freedom of motion, without perceptible shortening. Nearly four years after the injury Dr. Kinnaman and myself examined the case, measured both limbs, and were unable to detect the difference in length. The old lady said she had no pain in the hip, and she walked without perceptible limp or halt.

CASE 4.—Mr. —, aged 50, a bridge carpenter, large, fleshy man, fell from a bridge, some twenty feet; not certain how he alighted; resulted in fracture of right femur, through shaft at upper fourth, and also through neck—intra-capsular. Treated case by double extension with sandbags, to keep middle fragment the more secure. Result: union in five weeks, with one-half or three-fourths inches shortening; limb useful.

CASE 5.—Mr. C——, 86 years old, fell on the ice, 25th day of November, 1892, striking on right hip. The dressing was not applied for two weeks; during that time the old man suffered constantly, hip badly swollen and exquisitely tender; bed-sores formed in the meantime. The case was one of the severest tests of the treatment that would likely ever occur, viz.: extreme age, feeble constitution, bed-sores, and long delay in application.

All tenderness of hip, together with swelling, disappeared in two days after application of extension; pain was immediately relieved, and the old gentleman slept quietly all night following the application, without morphine—the first respite since injury. Union took place in four weeks so that the thigh moved freely at hip-joint. Unfortunately, the old gentleman's feeble constitution was unable to rally and gradually succumbed to bed-sores, after lingering a little over three weeks.

We submit these five typical cases of intra-capsular fractures of the neck of the femur, ranging in age from 52 to 86. All having the diagnostic symptoms of intra-capsular fracture, all would warrant an unfavorable prognosis, as based upon the best results of cases treated according to modern surgery, which we summarize by quoting Dr. Frederick E. Hyde's conclusions from an examination of twenty cases of fracture of the neck of the femur after several years from the date of the fracture. Thirteen of the cases had been diagnosed as intra-capsular, and seven as extra-capsular.

All were shortened, the shortening ranging from three-eighths of an inch to two and a quarter inches in the intra-capsular fractures, and from one-quarter to one and a half inches in the extra-capsular.

All or nearly all were suffering with more or less pain and stiffness about the joint, and walked with manifest halt.

We quote these results as being the best that have been obtained by the treatment recommended by modern surgery, which I here summarize without giving the names of the authorities:

Long side splint, with extension, as in other fractures of the femur; weights for extension and sandbags along the thigh; splints of leather, wire or plaster-paris, fixing the hip-joint in an immovable position.

We ask you to consider, in all candor, the following propositions:

(a) Will simple extension alone be likely to replace the broken and displaced fragments in the intra-capsular fracture?

(b) Will a dressing of plaster, of leather, or of wire, fixing immovably the joint, and pressing it firmly against the pelvis, be likely to secure good union in fragments already displaced?

(c) Would we have better results in other fractures of the femur if no more rational means were used in securing coaptation of the parts?

(d) With indubitable evidence accumulated of late years of bony union in intra-capsular fractures, is it but fair to attribute more to the mal-adjustment, and less to nature, than has heretofore been taught?

Elected.—Dr. R. D. Mason, of Missouri Valley, Iowa, has been elected to the Chair of Proctology in the Creighton Medical College (Omaha). The doctor will soon favor our readers with an original article.

NEURALGIA OF THE ABDOMINAL BRAIN AND MESENTERIC PLEXUS.

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1. Hyperæsthesia of the Abdominal Brain.—Neuralgia-cœliaca consists of a sudden violent pain in the region of the stomach. The pain is accompanied by a sense of fainting and impending anxious dread. It manifests itself, objectively, chiefly in the circulation and facial appearance. The skin is pale, the extremities cold, the muscles assume vigorous contractions, especially over the abdomen, and the heart beats under tension and may intermit. The abdominal muscles are put on a stretch. Some patients are occasionally relieved by pressure on the stomach. From the intimate and close anatomical connection of the abdominal brain with all the abdominal viscera and also the thoracic viscera, various other symptoms of a similar character to neuralgia-cœliaca may and do arise, as disturbance in the action of the heart and of the gastro-intestinal tract. The attacks are irregular, periodical, uncertain in time and intensity. The attack may last a few minutes to half an hour. The attack may disappear slowly or under a crisis of perspiration, eructation of gas, vomiting, copious urination, leaving the patient apparently very exhausted. The peculiar characteristics of the attacks in the abdominal brain differentiate neuralgia-cœliaca from inflammatory processes of the stomach.

The most typical neuralgia-cœliaca ever coming under my notice was (1887) that of a man about 40, a real estate dealer, in whom it had persisted for perhaps ten years. I could discover no gall-bladder trouble or heart trouble and no stomach lesion. He was attacked irregularly, however, depending on overexertion, several times a year. When attacked he felt that impending death was at hand. He screamed between paroxysms and would fall on the floor, rolling in agony for a half or three-quarters of an hour. He anticipated the terrific attacks by preparing for them with great care of his health. He would be very quiet for one or two days subsequent to the attacks; otherwise he was quite healthy. I soon lost sight of him.

The second most typical case of neuralgia-cœliaca in my practice was that of a woman (1883) about 28. She had very severe and frequent attacks which lasted some fifteen minutes, seemed to have terrible dread and anxiety, a wiry, small pulse, rigid abdominal muscles and varying pupils during the attack. She appeared greatly relieved by pressure directly on the stomach during the attack. She recovered with much exhaustion and relaxation; otherwise she appeared well. She died of carcinoma of the stomach, some twelve years later. Neuralgia-cœliaca may exist in very various degrees of intensity and duration. In some very severe attacks it would seem from appearances and the patient's report,

that the suffering was more profound than an ordinary death. The chief valuable treatment consists in securing active secretions of the skin and kidneys with free bowel evacuation. General tone is secured by tonics and wholesome food; even temperature and quiet life tells the rest of the story. The treatment during the attacks is purely expectant—sedative and stimulants. Vigorous baths and wholesome suggestions are valuable. There is often more in the advice given with the medicine than in the medicine itself.

Neuralgia-coeliaca resembles angina pectoris more than any other neuralgia of the sympathetic ganglia. It requires judgment and skill to diagnose it from some forms of angina pectoris, and its treatment is equally doubtful. Of course, it is physical lesions which we suspect in neuralgia of the abdominal brain, as the physicist cannot consent to the view that a machine (the sympathetic ganglia) may go wrong without it becomes structurally defective somewhere. Electricity, massage and cold packing are quite effective. Some writers consider this subject under the terms gastralgia or gastrodynia. But under whatever term it may be discussed, the peculiar sense of fainting, the anxiety, dread and feeling of impending destruction of the very center of life itself during the attack, and especially its action on the vascular system, sufficiently characterizes it as neuralgia of the abdominal brain—neuralgia-coeliaca. The diseases of the vagus manifest themselves otherwise.

2. Hyperæsthesia of the Mesenteric Plexus, Neuralgia-Mesenterica, enteralgia, enterodynia, or colic, signifies pain in the region of the bowel supplied by the nerves accompanying the superior mesenteric artery; *i. e.*, the region of the small intestine and the large bowel from the appendix to the splenic flexure. The pain is irregular, dragging, sickening, pinching, boring, accompanied by a sense of tenderness over the abdomen. The pain shifts from one segment of the bowel to another. The pain is generally located below the umbilicus and alternates with intervals of cessation. The pain does not generally begin suddenly, but gradually ascending to a maximum. It may be so severe as to induce a sense of faintness. Some patients assume positions to ease the pain, as pressing the hands on the abdomen, bending the thighs on the abdomen. Some patients are very restless under the attacks. The abdomen may be distended with gas or retracted. The attack may pass off with crisis, as the passage of gas, vomiting, sweating, profuse urination. The attacks last from a few minutes to several hours. Some patients are subject to these attacks for some months in succession. The patient may have intervals of entire freedom from the attacks. Yet the general observation is that constipation characterizes patients with mesenteric neuralgia. It is understood here that the pain does not arise from a recognizable, demonstratable organic lesion, as ulceration of the mucosa, lesion of the bowel wall or serosa, but from a nervous base. The pain may be merely short, sharp twinges, which some neurotic women describe year in and year out. The clinical picture of the disease offers manifold variations. Some patients have meteorism, pain about the navel, rumbling (borborygmus) in the bowels. Some have gurgling in the intestines, which appears to be due to a sudden irregular contraction of the bowel which rapidly forces the contents onward. In fact, patients with neuralgia-mesenterica often possess a catalogue of other

neurotic manifestations. Nausea, dysuria and tenesmus may be present. The chief accompaniment of this disease is, perhaps, constipation. However, the pains of mesenteric neuralgia should not be confounded with those of intestinal colic. The first author of celebrity who wrote with clear views on the distinction between neuralgia-mesenterica and intestinal colic, was Thomas Willis (1622-1675), an English physician well remembered by anatomists in the "circle of Willis," in numbering the cranial nerves, and in the nerve of Willis (the spinal accessory). The able Willis observed over 230 years ago that mesenteric neuralgia was not a disease, but merely a symptom. He said it should be distinguished from the vulgar term, the gripes (intestinal colic). Willis also noted what others see to-day: that the more violent attacks of mesenteric neuralgia generally have regular periods and follow the changes of the weather and the season; when once excited, they yield with difficulty to remedies, do not pass off quickly and may persist for weeks with great violence. In regard to the seat of pain, it may be noted in the same individual, it generally repeats itself in the same regions. The nerve tract sufficiently defective to harbor a neuralgia tends to retain the defect throughout life. It may be remembered that the superior mesenteric nerve supplies over twenty feet of small and nearly three feet of large intestine—a vast area, and besides the small intestine shifts very much daily; hence, the pains of mesenteric neuralgia may be in the lumbar, umbilical and hypogastric regions. If the pain occurs at the pit of the stomach, it is likely located in the transverse colon.

The clinical picture of mesenteric neuralgia is so manifold in its aspect that it requires the best heads and the finest skill to unravel the complicated symptoms. The differential diagnosis is difficult. In certain cases where the symptoms lessen after the evacuation of peculiarly formed rolls of mucous, there is a mixed neurosis.

Again, the mesenteric neuralgia, while it exists, may be complicated by attacks of asthma, nausea, dysuria, hysteria or other nervous affections, to which subjects afflicted with mesenteric neuralgia are prone. In cases of mesenteric neuralgia, certain regions of the abdominal skin may show hyperæsthesia from the connection shown to exist between the viscera and the abdominal skin. Mr. Head, of London, in "Brain," 1894, demonstrated the close relation existing between the nerves of the abdominal viscera and the nerves of certain skin areas. Hence, in cases of mesenteric neuralgia, hyperæsthesia skin areas on the abdomen may be expected. In the incipiency it may be difficult to differentiate a beginning peritonitis from mesenteric neuralgia. But of worth in such a diagnosis as peritonitis, is temperature, pain on pressure on the abdomen, general pain and increase of pain by deep pressure on the abdomen. With time the meteorism, singultus, and exudates become more evident in peritonitis. In gallstone colic tenderness on pressure arises and is localized. Icterus may follow to aid. Renal colic is differentiated from mesenteric neuralgia by its being localized in the region of the kidney, by its continual radiation along the ureters toward the bladder and testicles, by the severe dragging character of the pain and by the occasional expulsion of a calculus; yet renal colic in certain cases may so simulate mesenteric neuralgia that differential diagnosis is very difficult, if not impossible. This might oc-

cur when the renal renitiation flashes to the abdominal brain, becomes reorganized and radiates along the vast area of the superior mesenteric nerve. An ulcer in the bowel shows constant localized pain on pressure. The patient's history, the omission of the characteristic periodic attacks, the formation of the stool, aids in diagnosing ulcer of the intestine. It may be impossible to make a differential diagnosis in the incipient stage of the disease.

The most typical species of mesenteric neuralgia known to the writer is lead colic, *colica saturnina*. Lead colic is preceded by a stage of constipation accompanied by oppressive pains in the abdomen, chiefly about the umbilicus. Nausea, eructations, destroy the appetite. Pinching, twisting and drawing pains occur with different duration and intensity. The pains are often persistently localized, do not frequently shift, occur in paroxysms. The pains of lead colic, mesenteric neuralgia, are apt to arise to the highest pitch at night, and when they lessen are apt to leave annoying sensations, allowing little rest during the intervals of paroxysms. The diagnosis is aided by the patient's occupation, history, association, condition and state of climate. Arthritis, rheumatism and malaria induce neuralgia.

Having established the diagnosis of mesenteric neuralgia, the treatment will refer, to a certain extent, to the ætiology. Older practitioners relied too much on evacuation and opium. Modern practice attempts to correct the malnutrition.

The first symptom of significance in mesenteric neuralgia is pain. The second symptom of importance is constipation. Both symptoms demand vigorous attention. The treatment will first consist in attempting to establish the ætiology of the mesenteric neuralgia. Is it due to diet defects, spirituous liquors, narcotics, intestinal contents, coprostasis, *colica flatulenta*, animal parasites, metallic poisonings, or catching cold?

Or, again, is the neuralgia due to general nervous affections, as neurasthenia, to an exalted irritability of the bowel nerves and ganglia? Is it caused by hysteria or locomotor ataxia? Or is the mesenteric neuralgia induced by some diseased abdominal viscus reflecting its irritation to the abdominal brain, whence reorganized it is flashed over the vast area of the superior mesenteric nerve, crippling the bowel in whole or in segments? An investigation of the above considerations will influence the treatment.

First, the pain, real or pretended, will demand attention. Opium should be avoided, if possible. Valerian, assafœtida, *i. e.*, drugs with effect on the sense of smell, influence favorably, but perhaps there is more in the suggestion or advice which accompanies the drug than in the drug itself. I have observed better results from hot moist poultices (corn-meal), making the poultice a foot square and three to six inches thick and applying it over the abdomen. Cold packing of the abdomen in heavy, wet towels often does well. Electricity has good moral and physical effects. A hypodermic of morphine, one-sixteenth of a grain, is effective. However, we must admit that a good dose of opium, *e. g.*, one-half to one grain, works wonders for a time in mesenteric neuralgia. The bromides are slow but effective; however, they generally disturb digestion. Potassium bromide should be avoided as it irritates the mucosa and skin, frequently calling up rashes. Twenty to thirty grains of sodium bromide will

produce a quiet nervous system, especially inducing restful nights and quiet sleep.

The pain of mesenteric neuralgia being disposed of, the more important subject of the curative treatment should be carefully considered. The most important symptom after the pain is that of constipation. The bowels are indolent and are affected but slowly even by active purgatives. The evacuations are scanty and difficult to perform. The feces are dry, globular in shape and brittle. The patients are distressed by fruitless strainings. It is useless to attempt to cure such patients without a strict and rigid regimen. In the first place, such patients will not drink sufficiently, and secondly, they lack a regular hour for evacuation. I have treated scores of patients successfully for the constipated habit by directing that a large tumblerful of water with Mg. So₄., a half to a dram dissolved in it, be drunk every night. Also that the patient be directed to go to stool every morning after breakfast, *i. e.*, after the hot coffee is drank, which aids peristalsis. Direction should be given to eat food which leaves a large bulk of residue, as oat-meal, corn-meal and graham bread. This residual bulk stimulates the intestines to active peristalsis by contact in every successive segment. Daily massage of the bowel and electricity aid to rouse the indolent digestive tract to normal activity. The constant use of a very small pill of aloin, belladonna and strychnia is very effective. Colonic flushings two to four times weekly, salt water, and friction baths, aid nature in restoring lost tone. Change of environments, climate, a sea voyage, but perhaps better, long daily walks, are beneficial. Horse-back and bicycle riding are beneficial. The course of mesenteric neuralgia as regards life is favorable, the attacks which vary very much as regards intensity endure from one to several hours. Neuralgias arise in the sympathetic. Collins demonstrated that the arteries of the abdominal viscera were possessed of great sensibility in which the arteries of other parts were wanting. It is likely that the nerves accompanying the mesenteric artery participate in the reflex irritation, inducing the neuralgia.

The Doctor's Window.—This is the title of a work of much interest to the profession, edited by Ina Russelle Warren, for several years the editor of *The Magazine of Poetry*. It consists of poems by the doctor, for the doctor, and about the doctor, selected from a wide range of authors, from Chaucer to the present time, not neglecting Field, Carleton, Riley, Foss, Holmes and other favorites. The mechanical part of the volume will be first-class. The type was cast especially for the book, the paper will be handmade deckel, and the size of the volume 7x9 3-4 inches. It will include several photogravure engravings, and will extend to about 300 pages. The publisher desires to place a descriptive circular in the hands of every physician and druggist in this country, and a postal card will be promptly answered by him.

We understand that the book is to be put on the market by the subscription plan, either direct from the office of publication, or through traveling representatives who will handle the book in conjunction with some staple article. The publisher is Charles Wells Moulton, of Buffalo, N. Y.

ATROPHIC RHINITIS TREATED WITH TRIKRESOLIODIN.

By FAYETTE C. EWING, M. D., of St. Louis.

Fellow of the British Rhinological, Laryngological and Otological Association;
Laryngologist to the Missouri Baptist Sanitarium, and Surgeon to the
Out-door Department for the Throat, Nose and Ear, Etc.

THE following case is reported because of the comparison it institutes in the treatment of a typical case of atrophic rhinitis by trikresoliodin and the more routine method. The faithfulness with which the latter was pursued prior to the adoption of the former, renders the improvement under the trikresoliodin more worthy of note.

In the spring of 1896 I was consulted by Mrs. H., aged 33, for catarrh. Upon examination, found a condition of general atrophy and extensive crust formation. So pronounced was the tendency to crust, that but twenty-four hours were required to form a membranous cast which could be blown out intact, after the manner of croupous rhinitis. There were very severe headaches, and impaired taste and smell. The patient remained under treatment four months, during which time medication was employed in the office and at home. The office treatment included galvanism by intra-nasal electrode, spraying with a nasal wash approximating Seilers', and the painting and spraying of the Schneiderian membrane with a solution of nitrate of silver as strong as could be borne without prolonged discomfort. Later, the iodine, iodide of potash and glycerine mixture was substituted for the nitrate of silver. These applications were made regularly three times a week. At home she cleansed the passages with a solution composed of—

℞	P. Natrii bicarb.....	1 part.
	P. Natrii biboate.....	1 part.
	P. Natrii chloridi.....	2 parts.
	Mix. Sig.—Half teaspoonful to a glass of warm water.	

Three times daily she applied with an atomizer—

℞	Menthol.....	gr. v.-x.
	Eucalyptol.....	m ij.
	Thymol.....	gr. i.
	Benz niol.....	ad. ʒi.

The conscientious carrying out of this treatment through the period aforementioned accomplished no very appreciable improvement. The patient expressed herself as more comfortable, but this might have been expected as a result of the extra hygienic care. The crusting was not diminished, nor were the other abnormal symptoms materially modified.

In April, 1897, my attention was directed to trikresoliodin, and I wrote Mrs. H. to call at my office. I directed her to use the remedy twice daily, from the glass pyrozone atomizer of McKesson & Robbins, after cleansing the membrane with the salt and soda solution above mentioned. No office treatment was employed. She has called to see me at intervals of a month, and, though she is not cured, the improvement has been notable upon each visit. Taste and smell have become perceptible, and the Schneiderian membrane presents a healthier and more moist appear-

ance. Crusts still form, but in less quantity. Her headaches have disappeared, though it is but fair to say she attributes this latter phenomenon to an illness she had, for which she was treated by her family physician. Asked the nature of this illness, she declared she did not know, and did not think the doctor did, either. Her health is much improved, and from a condition of anæmia she has developed into a buxom woman, upon whose cheeks are "the red and white that nature's own cunning hand laid on." But whether the improved physical tone is due—as she supposes the headaches to be—to the illness, or benefited rhinitis, "deponent saith not."

MEDICATION IN VAGINAL DISEASES BY CAPSULED TAMPONS.

By JOHN R. BROWN, M. D., of Columbus, O.

PERMIT me to call the attention of the profession to one of the most useful, ingenious and complete modes of treating many diseases of the womb that it has been my good fortune to try. I allude to "Dr. Anderson's Antiseptic Vaginal Capsules," with absorbtive filling, manufactured by the Hall Capsule Co., of Cincinnati, O. By the use of this capsule the physician is saved the nauseating performance of introducing caustics or other applications of cotton, forceps, sound, etc. All that is necessary is to introduce your medicament on absorbent cotton in the capsule, close it and then introduce it, and the work of application is done. By means of a string there is no trouble in removing the cotton. Owing to the softness and easy pressure, the patient feels no inconvenience whatever. As a pessary, I regard it the best I have ever seen.

The first case in which I had occasion to use the capsule, was with a lady 36 years of age, with extensive ulceration of the os uteri. She informed me that she had been under treatment of various physicians for three years, but could not see that she had improved. In addition to the ulceration was anteversion, discharge free and very offensive, so much that she dreaded society. The terrible strain upon her was wrecking her system. About the middle of last November I commenced treating her by means of "Dr. Anderson's Antiseptic Vaginal Capsules." For the first ten days the discharge was so great that the capsule was changed twice in twenty-four hours. As she improved, it lessened rapidly and a change once in twenty-four hours was sufficient. But by the first of January she had gained eight pounds. At the present writing no ulcers have appeared.

The benefits derived from its use as a pessary, certainly command the intelligence of physicians. I have also used the capsule in several cases of leucorrhœa with better success than any other mode I have tried. While I am not quick to run after strange gods, yet I candidly believe the physician who will give this capsule an impartial trial will agree with me that it is the easiest and best means of treatment known, as the medicine prescribed comes in contact at once with the diseased parts and is retained there until it is absorbed.

PAQUIN'S SERUM IN TUBERCULOSIS.—REPORT OF CASES.

By E. A. WOOD, M. D., of Sedalia, Mo.

CASE 1.—James P., age 20, family history fair. In May, 1896, had pneumonia, previous to which his health had been fair, excepting a winter cough. July 28, 1896, his condition was as follows: Left lung mostly consolidated, impaired respiration in right lung; respiration 42; pulse 120 to 150; temp. 101 to 103; constant violent cough; expectoration profuse; emaciation extreme; weight 120. Microscope showed a case of mixed infection. Treated him one month with creosote—no improvement; then began the use of anti-tubercle serum in connection with tonic treatment. November 15th the patient was discharged—his condition was as follows: Temp. normal; respiration normal; pulse 90 and regular; both lungs clear; weight 160. July 1, 1897, is working on a farm and seems to be perfectly well; pulse normal and weight 170.

CASE 2.—J. W., age 26, family history not good. Had a hemorrhage in July, 1895, and another in October, 1896. His cough was severe; expectoration great. October 24, 1896, his weight was 132; temp. 99 to 101; pulse 102; lower lobe of left lung was infiltrated; rough respiration in right lung; bacilli found in large numbers. Serum injections begun at once. April 8, 1897, operated for fistula in ano. May 22d, no cough or expectoration; no fever; pulse and respiration normal; weight 161 lbs.; feels well.

CASE 3.—Mrs. S., age 20, has one child fifteen months old, family history fair, but was always anæmic herself and never was very well. Since the birth of the child her lungs rapidly became involved. December 1, 1896, her left lung was mostly infiltrated; coughed a great deal, but expectorated little; temp. 101 to 104; pulse 144; respiration 42. Microscope confirmed diagnosis of mixed infection. Gave serum injections quite regularly to May 1, 1896. Her temp. was normal most of the time, occasionally 100; respiration normal; pulse 108 to 120; some gain in strength but none in weight. She then went to another city on a visit and took bowel trouble from which she has not yet fully recovered. She left off the serum while absent. She coughs and expectorates some; can hardly expect a recovery, because of the persistent anæmia.

CASE 4.—Mrs. D., age 26, family history bad. Begun with whooping-cough in December, 1894; constantly grew worse. February 1, 1897, I found both lungs largely infiltrated; respiration 30; pulse 150; temp. from 89 to 103½; violent cough; profuse expectoration; constant sweats; weight 82. Bacilli present in large numbers. Gave serum in doses from 30 to 60 minims daily, also tonics. April 26th, her pulse ranged from 108 to 120; temp. 96 to 102; appetite good; no sweats; weight 88; feels well. May 12th, took cold while riding, rapidly grew worse and died May 12th.

CASE 5.—Mrs. B., age 33, family history good. Had tuberculosis for three years; traveled a great deal, but grew worse. February 11, 1897, large cavities in left lung; right lung infiltrated; respiration 54; pulse 120;

temp. $102\frac{1}{2}$; larynx badly involved; could not talk or swallow without a local anæsthetic. She was almost moribund, but pushed the serum. March 15th, respiration 24; pulse 96; temp. 101; throat was better from local treatment. No sweats; sleeps better; feels better. April 1st, severe changes in the weather and she rapidly declined and died April 10th.

CASE 6.—Miss W., now under treatment, age 22, has coughed for two years. June 21st, expectorates a great deal; weight 121; pulse 132; temp. 101; respiration 30; upper portions of both lungs dull on percussion; bacilli found in large numbers; begun serum at once. July 19th, pulse 90; temp. normal; respiration 24; weight 126; cough and expectoration less.

SYPHILITIC PIGMENTATION.

By A. H. OHMANN-DUMESNIL, of Saint Louis.

AMONG the signs which attest to the existence of a former eruption of syphilis and, consequently, as evidence that the disease has existed, is the syphilitic pigmentation. Every practitioner of medicine and every surgeon places much reliance upon this sign and, unfortunately, too much in some cases. For it must not be forgotten that quite a number of non-venereal cutaneous troubles but too often leave traces behind them in the form of pigmentations, and it often requires a well-trained eye coupled with experience to establish a positive differential diagnosis. For this, among other reasons, it has seemed proper to me to dwell at some length upon a subject which might, under ordinary circumstances, seem rather trivial to the reader. Cases do arise in which it is necessary to make out a history of syphilis in order to cure some condition present which may be due to the disease. If the objective lesions of the skin negative the former presence of lues, much unnecessary experimenting is avoided; and if the lesions which are present are pigmentations, care must be taken to recognize them and their cause in order not to fall into an error which might ultimately lead to irreparable consequences. I have seen freckles of large size mistaken for syphilitic pigmentation, and flea-bites taken for a small papular syphilide in the same individual. One symptom was apparently confirmatory of the other, and but for timely interference the patient would have been subjected to a long course of useless medication. Not only is such a consequence to be feared from a purely medical point of view, but the social consequences are apt to become quite disastrous to the individual from a social standpoint. For instance, a young man who has matrimonial intentions presents pigmentary stains and is told that he is suffering from an old syphilis may strenuously and very correctly deny that he ever had the disease. But when he is told by his uninformed medical adviser that he has suffered from "ignored" syphilis and that he presents indubitable signs of the disease, he will in the majority of instances simply abandon all thoughts of getting married and fall into a state of utter hopelessness, always a prey to anxiety in a fear of what will never happen and continually on the alert to see that which it is impossible should occur. It is the

avoidance of such consequences which should lead the practitioner to carefully consider the subject of cutaneous pigmentation, its different varieties and manifestations, as well as its various phases in different cutaneous troubles, in order to be able to avoid making what might prove to be a serious mistake.

It may be stated, in general terms, that it is an almost inevitable condition, or rather sequence, for syphilitic cutaneous manifestations to be followed by more or less marked pigmentation. A peculiarity in connection with this pigmentation is that it is more marked in color and outline in those cases in which but little or no attention has been paid to the employment of external applications to the syphilides which have occurred. In those cases in which there has been complete neglect in regard to the local treatment of the eruption, it will be found that the pigmentation is most intense, and the color is still more heightened if the individual be one having a dark complexion. It will require very little observation to demonstrate that blondes do not exhibit as marked pigmentary changes of the skin as brunettes do in ordinary cutaneous troubles, and the same holds true in syphilis. A very small amount of observation will readily demonstrate the fact that blondes do not show dark pigmentations, and care should be taken not to overlook them on account of their apparently mild character; nor, on the other hand, should it be supposed that because syphilitic pigmentation is dark in a brunette it is necessarily of a severe type or an indication that the primary lesions were of a particularly severe or malignant type. In any event, the very presence of the pigmentation is a matter of some interest, as it is a sign which plainly indicates the importance as well as necessity of giving the proper care and attention to all cases of syphilitic eruption, in the way of appropriate external applications, and also shows, in great part, the reason why the more careful writers on syphilology generally insist upon local treatment as a necessary adjunct to the internal remedies which are administered.

It may not be inappropriate to give a sort of general classification of the various forms of syphilitic pigmentation which are observed. In the first place, all may be divided into two general classes—the idiopathic and the symptomatic. The idiopathic are such as follow simple non-destructive lesions, such as the roseola, papules, etc. These have a tendency not to be as deeply pigmented as in the other class. The traumatic syphilitic pigmentation embraces those stains which follow lesions that destroy a whole or part of the cutaneous tissue, such as deep pustules, ulcers, cuts, burns, etc. It must not be forgotten that traumatism inflicted upon a syphilitic, more especially during the early secondary period, are followed by marked pigmentation. Another peculiarity of traumatic syphilitic pigmentation is that it is more deeply colored than the idiopathic.

The varieties just mentioned may be subdivided, each one, into the small and large. The small pigmentation varies in size from a small pin's head to the small finger-nail, whereas the large varies from the size of the small finger-nail to that of a silver dollar, or even larger—that of the palm of the hand. The size is, of course, governed by that of the lesion which preceded the pigmentation, so that no fixed rule can be given in regard to the size attained or shown. This can only be determined by an examination of a case while the eruption or lesions are present. Of course, the

pigmentation present, its color, size, and length of persistence, may give a certain more or less distinct idea of the condition which pre-existed. The distribution of the lesions in syphilitic pigmentation may be discrete, disseminated or confluent. In the discrete form the stains occur here and there, and, as a usual thing, are not numerous. This is, perhaps, the most common, or, at least, that which is most frequently seen. Not more



FIG. 1. Disseminated Syphilitic Pigmentation.

than from two to six finger-nail size stains may exist. In the disseminated form we have a condition characterized by the presence of numerous stains which vary in size. A good example of this is shown in Figure 1. A limb, a portion of the trunk, or the entire body, may be involved. In the confluent syphilitic pigmentation we have a condition presented which is

far from being a common one. In this form a large area is involved, but it is the rule that certain portions of the skin remain normal. In fact, upon a superficial glance it would lead an unpracticed eye to pronounce the trouble one of vitiligo. The peculiarity of the contour of the healthy



FIG. 2. Confluent Syphilitic Pigmentation.

skin will readily dispel any such idea, and a careful examination will readily show that, instead of a loss of pigment declaring itself, the coloring matter is, in reality, encroaching upon the normal skin. A representation of a case of this rather rare condition is shown in Figure 2, which

shows very plainly the difference in tint of the normal and of the pigmented skin in a syphilitic whose complexion was quite dark. In this form of the trouble care must be taken not to mistake it for other forms of extensive pigmentation. Thus, for instance, we have so-called "vaga-bond's disease," which is due to filth and parasites causing an intense pruritus, and the efforts to relieve this by scratching cause a black discoloration of the skin by reason of the dirt on the surface and under the nails being deposited under the upper layers of the skin. Again, we have an extensive pigmentation occurring in Addison's disease, and, although not quite so dark as in syphilitic pigmentation and having the peculiar bronzed tint so characteristic of the disease, it may prove deceptive to one who has not closely studied these colors; and this very fact of the possibility of making an error should make observation more keen and discriminating.

It is by no means an unusual thing to find, in a case of syphilis in which an extensive eruption of papular, pustular or papulo-pustular syphilides have occurred, large and well-marked pigmentations such as are delineated in Figure 1. This is the class of cases which should be studied in order to be able to master the various peculiarities which go to make such a condition characteristic and enable the observer to pronounce his views definitely in regard to any given case. The apparent lack of attention which has been devoted to the subject renders it positively imperative to devote some study to it, and it will be found profitable to do so. As has been stated above, these pigmentations occur in cases in which there has been but little or no internal treatment, or one which has been entirely inadequate to the condition present, and, in addition, no external treatment at all. Nor must it be forgotten that even efficient treatment will not be successful unless it be followed for a certain length of time, such as the exigencies of the case may call for. A specific treatment for a few months is certainly not sufficient, and taking remedies spasmodically will never succeed. Whatever treatment is taken must be prolonged over a sufficiently long period of time—one and a half or two years—and then there is good ground to expect an immunity from all danger of any tell-tale pigmentation.

As has been already mentioned, the syphilitic pigmentation may vary considerably in size and color. In form it may be roundish or ovalish, or of the form assumed by lesions which are confluent, or that characteristic of the trauma immediately preceding. It is of a brownish color, somewhat resembling that of copper which has been exposed to the air. Of course, the intensity of the tint varies a great deal. In the negro it looks black, in light blondes it is of a light tan color. The contours of these pigmentations are sharply defined and the borders are clean cut. There are no subjective symptoms whatever connected with these pigmentations. It is this very absence of any subjective symptom which will best serve to differentiate syphilitic pigmentation from the cutaneous trouble which most closely resembles it—*tinea versicolor*. The latter, which is of vegetable parasitic origin, and this is easily determined by the microscope, itches and desquamates to a certain degree, both of which are symptoms not met with in pigmentation. In *chloasma* we have a marked pigmentation whose color differs essentially from that of syphilitic origin, and there is, moreover, no history whatever of the existence of any previous lesion or eruption. By care-

fully considering these points and establishing the presence or absence of any concomitant syphilitic lesions, either primary or consecutive, a differential diagnosis can be arrived at with comparative ease. The pigmentary syphilide is one which might be taken for the pigmentation under consideration; more especially as it is a comparatively rare manifestation of syphilis. In this the pigmentation is not consecutive to some primary lesion and is not the result of any destructive process. It appears as such from the beginning and is an eruption *per se*. It is found to occur most generally in women, and it makes its appearance upon the back and side of the neck. There seems to be no record of its occurring upon the anterior aspect. The color of the pigmentation is very light, and it might at first glance be taken for an eruption of light freckles. Its peculiarity in distribution, however, would show that this is not the condition. It is at best a very unusual and even a rare condition.

Syphilitic pigmentation is rather irregular in its distribution. It is by no means necessarily limited to the trunk and extremities. It will show itself upon the face and hands, if those parts have been the seat of a syphilitic eruption. It is for this reason that there attaches some degree of importance to the prompt recognition of these lesions, more especially when in visible portions of the body, in order that there may be accomplished a rapid disappearance of these tell-tale marks of a syphilitic infection, which are to-day so readily recognized by the laity as indisputable signs of a former infection, and it happens very often that these disguises by the *vulgar* miss their mark.

The usual course followed by these stains, if they be permitted to take their own way, is for them to disappear gradually and ultimately pale in the center. This disappearance of pigment progresses slowly towards the periphery until there remains nothing but a narrowing of colored pigment which seems quite marked. This in its turn also becomes paler, and after the lapse of a longer period of time the whole discoloration disappears in its entirety. If there has been any considerable destruction of tissue, a white scar, either thin or thick, will remain and will become prominent on account of being much paler than the normal skin. The entire disappearance of the pigmentation is a consummation, however, not as readily attained as the patient could desire. It requires quite some time, many months in some cases, to arrive at this much-desired result.

From what has been said, it is quite apparent that the recognition of syphilitic pigmentation is a comparatively simple matter, and its treatment is equally so if the proper measures be adopted. The treatment of syphilitic pigmentation is preventive or curative. In the former instance energetic general treatment is, of course, essential; and if there be any eruption present, local measures are to be applied; and the prevention of the appearance of the brownish stain depends entirely upon the faithfulness of the patient in making the applications. Among the eligible preparations which will be found of value are the following:

R	Hydrarg. oleatis, 5%.....	ʒss.
	℥ i. olivæ, opt.....	ʒiijss.
M.	Sig. Rub in well once daily.	

If an oily preparation be objected to, the following may be employed:

℞ Hydrargyri bichloridi.....	gr. v.
Ammon. muriat.....	gr. x.
Spts. coloniensis.....	
Aquæ destillat.....	aa ʒij.
M. Sig. Apply twice a day.	

If the curative plan must be employed, much more radical measures are necessary. In the case of old pigmentations the following will be found of service, remembering that a 1 to 500 bichloride solution must be applied finally. Of course, active internal treatment must be given. The method is that of Barthelémy, and is a very good one, although somewhat troublesome.

℞ Resorcini.....	ʒx.
Zinci oxidi.....	ʒijss.
Glycerini.....	ʒss.
Adipis.....	ʒv.
Ol. olivæ.....	ʒij.
M. Sig. Apply several times a day.	

After using this for three days the skin becomes parchment-like and peels off. The following is then applied:

℞ Grenetin alb.....	ʒj.
Zinci oxidi.....	gr. xlv.
Glycerini.....	ʒjss.
Aquæ destillat.....	ʒij.
M. Sig. Apply twice a day for two or three days.	

In all cases of syphilitic pigmentation the prognosis should be guarded. The pigmented areas, when once established, will persist for a very long time, and all the internal treatment administered will fail to procure a good result or have any influence in bringing about its disappearance if not aided by external measures. Of course, the pigmentation will eventually disappear spontaneously, but may occupy years in its fulfillment. Energetic internal and external measures, however, will enable the physician to give not only reasonable hopes but a fair degree of assurance to the patient that the spots will disappear in a comparatively short space of time.

We Can Endorse It.—It is seldom that we feel called upon to bestow unqualified praise upon any article or institution, but we cannot withhold our editorial approval of that new school for practicing physicians, the Chicago Eye, Ear, Nose and Throat College, located in the Trude Building, Chicago.

This institution has for its purpose the instruction of practicing physicians in the latest and most scientific methods of treating diseases of the eye, ear, nose and throat.

Its faculty consists of men prominently known in the profession, engaged in active hospital work in Chicago. The course offered is a comprehensive practical study of modern scientific methods.

The hours of instruction are from 9 A. M. till 6 P. M. A concession always allowed is—in the event that a physician is called away during the term—he may, without additional charge, complete his course any time within one year.

THE PRACTICE OF MEDICINE IN THE REPUBLIC OF MEXICO.

By N. H. WHEELER, D. D. S., of Oaxaca, Mexico.

THE rapid strides made in the Republic of Mexico, in the last few years, in the development of its resources, made possible by the building and developing of the several lines of railroads, which render inter communication easy of accomplishment, as well as that from other countries, and especially from the United States, combined with the *free coinage of confidence*, inspired by the wise and intelligent government of President Diaz, has attracted the attention of many parties who have immigrated to this country with expectation of grand fortunes to be made with slight exertion.

That there are golden opportunities, no one can gainsay; but these opportunities are not for him who depends on his daily labor for support, or his professional skill to furnish and supply his home.

One of the first and principal requisites to the practice of medicine in Mexico is an acquaintance with the Spanish language, and this is imperative. An interpreter will not do, for every doctor knows there are cases where no third party could be tolerated. The time necessary to become familiar with the language will depend greatly on the capacity of him who expects to acquire it, and his application thereto, and a year's time will be the least. Diplomas of other countries are not recognized in Mexico; they are a good thing to have, however. To secure a diploma here it is necessary to pass an examination before a medical board, and this examination is in Spanish entirely. This examination is very strict and searching, and very few of the American physicians now practicing in the country have ever taken it. In the arrangement to practice medicine some formalities of law have to be complied with, which vary slightly in the different States. These generally consist in notifying the medical board and some of the officials of their intentions. The M. D. can then "strike out," but he has no standing in the law and cannot collect bills by its assistance. He must be very careful, also, not to make any mistakes in his prescriptions; in case of a death, he cannot sign the death certificate, which is always required, and without which no burial is permitted.

These matters are arranged by forming a partnership with a native physician, or making an agreement with some one of them to sign such certificates. The impression that the M. D.'s of Mexico are behind the times is erroneous, for there are many of them that would be an ornament to the profession in any country. In surgery they may not be up to the high standard of the College of Physicians and Surgeons, or Bellevue Hospital of New York, but for general operations they do creditable work.

The principal diseases which will require his attention are: fevers, typhoids and intermittents; pneumonia, which, in the higher altitudes, requires prompt attention; eruptive fevers are also common; indigestion in all its forms; liver complaints are all too common; and even the kidneys don't always perform their functions properly; rheumatic troubles are met

with in some sections more than others; all the ills of childhood are to be encountered in their various phases, and syphilis is rampant.

The sanitation of the cities is bad, and were it not for the climatic conditions, due to the elevation of all the interior towns, epidemics would be the rule, instead of the exception.

Fees are low, and will average about one dollar (silver) per visit, except in the City of Mexico, where they are some higher. "The poor ye have always with you," and it is the custom here for the M. D. to give an hour's practice each day to their service free.

Many inquiries have been made, and are being made, in reference to the advisability of the writers coming to Mexico to locate and practice medicine. There are many American physicians in the country, and in the larger cities there are from one to three or four. Many of them are doing well, others who may be superior in the profession are not. These are a peculiar people, and, if their fancy favors one, their doors and hearts are open to him; if they don't—well, he'd better stay at home and saw wood. In the smaller towns there is no show; he would starve to death.

To him who is anxious to come to this country to engage in the practice of medicine, we would suggest that he get all the information possible first. Then pack his instruments and books, go down to the ticket office and make minute inquiries concerning price of tickets, baggage, etc., weigh the matter well while he walks back to his office, answer the first call he has and keep at it.

ÆTIOLOGY OF GLAUCOMA.

By DUDLEY S. REYNOLDS, A. M., M. D., of Louisville.

Professor of Ophthalmology, Otology and Medical Jurisprudence in the Hospital College of Medicine, Medical Department of the Central University of Kentucky;
Surgeon to the Eye and Ear Department of the Louisville City Hospital, and the Gray Street Infirmary, Etc.

THE ætiology of glaucoma is believed by many to lie in some deranged state of the glandular organs deposited in the projecting portion of the ciliary body.

Recently Collins and others have revived the theory that it is primarily due to either an increase in the amount of aqueous humor secreted, or an obstruction to the drainage of the aqueous chambers through Fontana's spaces; and so Swanzy, Norris and Oliver, and many other recent writers conclude that narrowing of what is called the iris angle, the space between the periphery of the cornea and iris, obstructs the outlet through which the excess of humor escapes into Schlemm's canal. These gentlemen forget that the so-called iris angle is occupied by slips of the divided posterior elastic layer of the cornea, which constitute the pectinate ligament of the iris; and that the so-called spaces of Fontana are more imaginary than real. Schlemm's canal cannot easily be entered in this direction, and if it could this venous sinus, surrounded by resisting walls of scleral tissue, offers no elasticity for the accommodation of any variation of blood

pressure within. If the veins take the aqueous humor away, it must necessarily be that this fluid enters at the very origin of the vein, where the capillary tube ceases. This is the point provided by nature for the introduction of fluids of less density than blood serum. As the aqueous humor is poured out by a series of racemose glands, occupying the projecting part of the ciliary body, it is quite certain that an inordinate secretion of this humor must increase the depth of the aqueous chambers, and, as a matter of fact, there seem to be frequent variations in the depth of the space between the anterior surface of the capsule of the lens and the posterior surface of the vertex of the cornea.

We often observe injuries of the ciliary region followed by increased tension of the eye, morbid sensibility to light, dilatation of the pupil, and peripheral narrowing of the field of vision, as determined by perimetric measurement. Inflammatory changes taking place in the ciliary muscle necessarily disturb the nutrition of those parts to which the nerves, passing through this muscle, ultimately extend.

In rheumatic and gouty people, in people who have suffered mechanical injuries of the ciliary region of the eye, glaucoma is a common disease. One of the symptoms is an abnormally diminished depth of the aqueous chambers, the very opposite to that which an inordinate retention of aqueous humor would produce.

The peripheral narrowing of the field of vision marks the advance of inflammatory effusion into the periphery of the choroid, and, as the disease extends, this limitation of the field increases, *pari passu*. An inflammation having its origin in the ciliary muscle, or ciliary body, is always attended by those phenomena characteristic of glaucoma. It is impossible, therefore, for the mere advancement of the iris toward the cornea by a reduction in the amount of aqueous humor, or a merely accidental and temporary swelling of the ciliary body, if such a condition ever takes place, to constitute either the starting point or any essential feature of any of the conditions preceding an attack of glaucoma.

A well-known gentleman, discussing this subject in the Section of the American Medical Association, at Philadelphia, said: "The tissues of the iris secrete an albuminous fluid which blocks up the spaces of Fontana, constituting the beginning of the glaucomatous state." Verily, it would seem the study of histology must have been sadly neglected. To the glandular organs of the body alone is reserved the function of secretion.

Mr. Priestley Smith fancied a small cornea in the hypermetropic eye a predisposing condition to glaucoma. It has often been asserted by some that, as age advances, the crystalline lens undergoes an increase of size, and that this augmentation in the size of the lens reduces the circumlental space to a degree sufficient to cause intra-ocular tension. Another writer describes the eye as a lymph end organ, and concludes the supra-abundance of lymph in this end organ, the eye, determines an attack of glaucoma, whenever any extended irritation in the ciliary nerves arises to disturb the proportionate amount of aqueous humor secreted and eliminated. The lymph stream is recruited from the blood stream in precisely the same manner in all parts of the body where leucocytes escape through the walls of the capillary blood tubes.

To sum up, it may be stated that glaucoma is always an inflammation

of the ciliary muscle, or ciliary body, generally of both. That the iris always participates more or less in the inflammation; and that the peripheral portion of the choroid is early invaded. The only predispositions known are the rheumatic and gouty diatheses. A common exciting cause, independently of the diathetic conditions, is traumatism of the ciliary region.

Astigmatism, hypermetropia, and the prolonged use of the eyes by students and artisans, poorly nourished, may lead to incipient or chronic glaucoma. The prolonged use of the eyes in the presence of glaring light, with loss of sleep, may in some lead to augmented tension and peripheral narrowing of the field of vision. All the well-defined typical cases of glaucoma must, however, be admitted to occur in persons with rheumatic or gouty diatheses, or in those who have been the subjects of traumatism of the ciliary region of the eye.

The ocular tension observed in syphilitic irido-cyclitis, extending, in neglected cases, to the choroid, retina, and vitreous, sometimes ignorantly called iritis serosa, presents in no stage of its development any clinical resemblance to true glaucoma.

SOME POINTS IN CATARACT OPERATIONS.*

By JAMES MOORES BALL, M. D., of St. Louis,

Member of the St. Louis Academy of Medical and Surgical Sciences; Professor of Ophthalmology in St. Louis College of Physicians and Surgeons.

IN presenting a paper on the subject of cataract operations I feel that I need to make no apology. The operation is of great importance to the patient, there are so many points still in dispute, and the result of an operation has such an influence upon the reputation of the operator, that we should be willing to study the question in hand.

The extraction of cataract may be done with or without an iridectomy. The advocates of an iridectomy claim that the safety of the eye is greater after an iridectomy than when an extraction is made without it. They call special attention to the frequency of prolapse of iris after the simple operation; yet their statistics are slightly, if at all, better than the results obtained by the other method. The advocates of simple extraction, on the other hand, assert that iris prolapse does not often occur, and that it is not dangerous if present; and that it can easily be snipped off. And they say that an iridectomy subjects the eye to dangers to which it otherwise would not be exposed.

The advantages and disadvantages of the simple operation have been summarized by Knapp. The advantages of the simple extraction are:

1. It preserves the natural appearance of the eye.
2. The acuteness of vision, other things being equal, is greater.
3. Eccentric vision and "orientation," correct localization of objects in the visual field, are much better, adding a great deal to the comfort and safety of the patient.

* Read before the St. Charles County (Mo.) Medical Society, May 18, 1897.

4. Parts in direct connection with the ciliary body, such as shreds of the capsule and iris, are not so liable to be locked up in the wound and thus transmit morbid conditions to the most vulnerable part of the eye, the ciliary body.

5. It may not necessitate so many after-operations.

As disadvantages may be mentioned:

1. The technique of the operation is more difficult in all its parts.

(a) The section must be larger to let the lens pass through an aperture, the size of which is diminished by the iris lying in it; it must be more accurate to secure coaptation, and it must be more rapidly performed in order to prevent the iris from falling before the knife. (b) The opening of the capsule requires a deeper introduction of the cystotome into the anterior chamber. (c) The expulsion of the lens is more difficult; and (d) the cleansing of the pupillary area is much more troublesome than in the combined extraction.

2. Prolapsus of iris and posterior synechia are more numerous.

3. It requires quieter and more manageable patients during and after the operation than is needed in the combined extraction.

4. It is not applicable to all patients; whereas combined extraction can be used as a general method.

I learned to make this operation seven years ago, while a private pupil of Professor Snellen, of Utrecht. Before that time I had been operating with the iridectomy. As a result of an experience amounting to two hundred cases, I would lay down the following rules: where the patient is free from cough and urinary difficulties, such as stone, stricture or enlarged prostate, never make an iridectomy unless (a) the tension of the eye be increased; (b) the iris prolapse; or (c) one of the indications for iridectomy exists:

1. In operating upon private patients who are obedient and patient be so situated that you must leave the after-treatment in other hands than your own.

2. In operating upon inmates of our eleemosynary institutions, most of whom are not the best of patients, I always make an iridectomy because I have found iris prolapse frequent in these people.

3. I would not advise the beginner to make the simple extraction until after he has become expert in the combined operation. The making of an iridectomy does not always prevent iris prolapse.

The technique which I follow is this: The preparatory treatment consists of a bath and thorough washing of the head. The instruments are sterilized by boiling; every solution used about the eye before and after the operation is previously boiled and is placed in a bottle which was boiled. The solutions are three: cocaine (a five per cent solution); a bicloride solution (1:4000); an eserine solution (one-half of one per cent). The cocaine is used two or three times before the conjunctival cul-de-sac is washed with bichloride. The eye-dropper is boiled and then placed in the bottle of bicloride until wanted. Of course, I am always careful not to let any fluid get into the rubber cap of the dropper. I am sure that attention to the strict principles of antisepsis will save many an eye from infection. Here, as elsewhere in surgery, the finger-nails should be thoroughly cleaned. All gauze used is first boiled. There is no deviation

from this rule, no matter who has manufactured the gauze, and only gauze is used for sponging and as a dressing. The eye being cocainized, I speak kindly and reassuringly to the patient and begin. The incision is made in the cornea and includes a little less than one-half its circumference. The cut is made with a sawing motion, and the knife must be in perfect condition. A ragged cut does not heal kindly in all instances; moreover such a cut invites the presence of cortical matter. The incision being finished, a cystotome is introduced and the capsule is cut. The exact direction of this cut is, in my opinion, of minor importance, if the cut be a free one. Some operators make a crucial incision; others incise the capsule in the periphery parallel to the corneal section. The lens is then delivered in the usual manner. The iris often prolapses at this stage. No attention is paid to it until after the pupil has been cleared of all cortex. This is the most important step in the whole operation and requires a nice sort of dexterity. If left in the eye cortex will swell up and cause iritis, if indeed it does not produce infection of the wound. No bichloride solution is permitted to come in contact with the wound or enter the anterior chamber; for this antiseptic, valuable as it is in the cleansing of the conjunctiva, has no place in the eyeball, where it is sure to cause a striped keratitis; that is, a form of change in the posterior layers of the cornea often producing a permanent opacity and impairing the value of an operation. We next notice the iris; if prolapsed the prolapse is gently reduced by stroking the iris back into place by a delicate spatula. If not prolapsed, it is stroked anyway until the pupil is central. Gauze is now applied over the lids and secured by adhesive strips.

This dressing is kept moist with bichloride solution for four days, the dressing being changed every day. On the third day a drop of atropine solution is used. This is continued for a week or more. The unoperated eye is usually bandaged also for two or three days, although there are many obedient patients in whom this is not necessary. At the end of four or five weeks, if all redness has disappeared, the patient is fitted with glasses, search being made for any astigmatism present. Usually patients are given two pairs of glasses—one for reading, the other for distant vision.

What of the accidents attending these cases? I need not take up your time with these, but will say that if at the end of twenty-four or forty-eight hours there be prolapse of iris I do not wait one or two weeks before operating upon it, as advised by the books, but at once place the patient under chloroform, drag out as much of the iris as possible through the corneal wound, cut it off, and give careful attention to the edges of the iris coloboma. I have had no cause to regret this treatment. If there be a tendency to iris prolapse, as shown by a drawing up of the pupil toward the corneal wound, I use two or three drops of eserine. If there be any signs of an impending iritis, or if much cortex has been left in the eye, the atropine drops are used on the second day instead of the third or fourth, and continued indefinitely. If iritis is actually present, as shown by pain, irregularity of pupil and increased redness in the circumcorneal zone, moist heat is applied to the eye and a solution of scopolamine is dropped into the conjunctiva three or four times a day. I use scopolamine because it is more rapid in its action and more powerful than atropine.

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A TALK WITH ADVERTISERS.

The best proof of an honest circulation is the publication of post-office receipts regularly. It has too often happened that in the transactions between advertiser and publisher business principles have been ignored. While in all other transactions Shylock demands his pound of flesh, in the advertising business imagination runs riot and plays havoc with good judgment. It enables the advertising solicitor to see his circulation as he would have others see it, and it seduces the advertiser into believing the fairy tales told him by the solicitor. Advertisers do not seem to be aware that the "cold facts" of the advertising business are accessible, if they only demand to know them.

The circulation liars are abroad in the land seeking whom they may devour. They infest every class of journalism and are **Circulation Liars.** by no means rarely found in medical journalism. The advertiser who does not know the ins and outs of the publishing business falls an easy prey to the wolves. The stronghold of the circulation liar is the fact that his statements are rarely investigated. In the absence of an investigation he can claim almost any circulation and be safe. He can raise his advertising rates in proportion and acquire money rapidly. The claim of the circulation liar gives the advertiser a

false idea of what the circulation of a medical journal should be. He compares the modest figures of the honest journal with the attractive figures of the circulation liar, and often the honest journal is looked upon with distrust while the fakir sheet is greedily accepted.

Sworn statements are often resorted to by the circulation liar. He presents an elaborate and artistically neat document, giving affidavits from the printer, publisher, binder and devil, showing an immense circulation, when in

Sworn Statements. truth, he may have issued only a small number of copies. It is a notorious fact that such "sworn statements" can be had without difficulty. They are valueless, except that they place the fakir upon record and may be used against him if any one desires to institute criminal proceedings. Some medical publishers do not seem to know that this

An Indictable Offense. misrepresentation is an indictable offense, because it is obtaining money under false pretenses. It is strange that advertisers should look upon this form of robbery with so much complacency without even asking for proof of circulation. With so simple a method of proving circulation at hand, it is possible for every advertiser to get facts before he invests his money.

The advertiser would test a journal's circulation. How does he proceed? Does he ask to inspect the publisher's subscription books? Does he visit the printing office and watch the printing of the journal,

How To Test Circulation. or ask for Uncle Sam's post-office receipts? Oh, no! He tests the circulation by giving the journal a trial advertisement, and if he gets no immediate returns he condemns the journal as valueless, and brands it as a dishonest journal. This is not a fair test. A good journal may bring no visible results at first, but may be about to bear fruit when the trial advertisement is cut off. A good circulation in the right field will bring results sooner or later, and a journal with no real circulation will only cause a great waste of advertising money. Therefore, the advertiser should know before he invests his money just what and where the circulation of the journal is.

When the advertiser finds that he is wasting money he cuts down space wherever he can. How can he do this wisely? Retrenchment in no longer paying for what he does not get is infinitely better than a horizontal slashing of advertising space in an indiscriminate manner. He must find out where the padded circulation is and stop paying for it. He must not confuse the results from a good medium with baseless claims of another, which is so often done. He will be continually at sea until he has seen proof of the actual circulation of each journal.

The best proof of circulation—we had almost said the only proof—is the exhibition of post-office receipts from issue to issue. Nobody can fool Uncle Sam, and his receipts are now accepted by the shrewdest manufacturing houses as the only proof of a medical journal's circulation.

HONEST MEDICAL JOURNALISM.

The chief revenue of a medical journal is derived from advertisements. Advertisers generally wish to know that they get what they order and pay for. In this they are only human. If a doctor orders a meal at a restaurant or hotel, he expects to have the order filled correctly. So with the matter of advertising. The advertiser wants and is entitled to receive that which the medical publisher promises him.

Unfortunately for legitimate journalism there are not a few publishers of medical journals who claim immense circulations for their journals and sell space to advertisers upon the basis of a condition which does not exist. So frequently has it been found that such journals often print only one-tenth as many copies as they claim to have subscribers, that if an honest publisher states his circulation correctly, he often is not believed.

The only basis on which to do business with medical journals is for the advertiser to demand proof of the exact circulation. Such proof can be easily furnished by any publisher who will exhibit his post-office receipts for the number of pounds of each issue of his publication as it is mailed. Then, by a simple mathematical calculation, any advertiser can tell the exact circulation, and know whether or not he gets what he pays for. For the advertiser to demand such proof before paying his bills, according to our way of thinking, is neither a hardship nor a discourtesy to the medical publisher. If the publisher buys 1,000 reams of paper he has it counted before he pays for it. Why should not the advertiser be granted the same right?

Now, having arrived at these conclusions, THE TRI-STATE MEDICAL JOURNAL will begin the new year prepared to prove to any interested party, be he subscriber, advertiser, friend or foe, that we actually print and mail over five thousand (5,000) copies each month. In the February number we will print a *fac-simile* reproduction of our post-office receipts for January, and this plan will be followed throughout the year. Our *bona fide* circulation of 5,000 per month will more than equal the 10,000 to 20,000 *claimed* by Munchausen sheets. The circulation liars must take a back seat, for we have cleared the decks for action.

THE MEDICAL COLLEGE CRAZE.—A CIRCULAR LETTER.

To the Medical Profession of Texas:

Gentlemen:—No doubt, many of you have seen from the daily press that attempts are being made to organize a medical school at Dallas. A respectable portion of the physicians here, who hold no higher motive than honor to our noble profession, whose mission has ever been to unfold hidden truths and to bless mankind, have already entered their solemn protest against the above named organization, and we think it wise and judicious to give you our reasons and ask your co-operation. No sickness no doctor; no doctor no medical school. This sentence tersely and succinctly sets forth the right and true relation between the people, the doctor and the school. The only foundation at all for the existence of the medical profession as a separate body is the fact of human suffering, and

the only foundation for the existence of the medical school is the necessity to fit men to prevent, alleviate and cure human ills. Upon the right conception of the relationship thus set forth between the people, the doctor and the school, depends all that there is of honor, dignity and true service in our noble profession, and constitutes the foundation stone upon which our high calling is built, and ought forever to separate us from the spirit of commercialism, which, in these latter days, holds nothing sacred and attempts to put its trade-mark upon all things human and even divine. "Quæ omnibus prosunt," not "cui bono," should be inscribed upon our banner. A sincere and honest desire to serve our fellow-men being the governing motive of the true physician, should not the same noble ambition to serve their day and generation animate and control men engaged in the high vocation of teaching? When the question of establishing a school of medicine is discussed, the real honest question is not, will it pay; will it be good for the teachers; will it bring money to their purses, or will it advertise the professors; but is it best for the community and the profession; will it add usefulness or dignity to the already overcrowded profession? We have already 140,000 to 150,000 doctors in the field, and the diploma mills now grinding day and night with an annual output of 15,000 to 20,000 more. Isn't it time to pause and reflect; can there be any earthly excuse for even one more college? Would it not be infinitely better, if we could do so, to shut up and obliterate and abolish from the face of the earth 75 per cent of those colleges already in existence? Is it not a fact, that by the multiplicity of medical schools the doors have been thrown wide open to uneducated and unfit men, men unprepared to acquire or successfully pursue a learned profession, taking them from the shop, the field and the ranch, where they might have been producers of something valuable to themselves and their kind? Who amongst us does not have personal knowledge of those unseemly scrambles for students? The bars must be lowered for their matriculation and the bars must be lowered for their graduation. So we are forced to the conclusion that the multiplication of medical schools is the largest factor in the deterioration of our profession, in the loss of the dignity, morale and high tone that once characterized it.

But there are other objections of minor, but still important bearings. In addition to the unseemly scramble for pupils, which affects the country at large, here comes this objectionable feature, especially to the local profession, viz.: the keen, still hunt for clinical material. And the preserves of the honest, hard-working non-professor are unscrupulously poached upon in order that *the professor* may swell and strut and look wise things if he doesn't say them. Indeed, to such an extent do the private practitioners in some of our larger cities suffer that they are forming protective leagues among themselves to prevent these encroachments. Horrible to relate, many of these alma maters live and thrive and have their being from the blood of their offspring. They covenant and sell and deliver the diplomas, and then straightway, if the new-fledged doctors dare settle under the shadow of their walls, begin to filch their patients. Oh, sweet alma mater! We are glad to say, however, that here and there in our broad land, there are noble institutions, amply endowed, surrounded and crowded with clinical material, with high requirements for matriculation and graduation, where the earnest student can get every advantage, and if

he but comply with the requirements, can leave their halls with the assurance to himself and the promise to the people of at least a useful if not brilliant career. It is simply impossible to establish and maintain a school of this grade at Dallas. In the first place, the necessity for the school does not exist. We are in less than a day's ride of fifty schools—in less than forty-eight hours of 200 more—of all classes and grades—from Cheap Johns up to the highest and noblest institutions that grace and bless any land. Then, again, it is simply idle to claim for Dallas the required clinical material. In the history of all professions there comes a time when the good and true men are expected to stand firm. That time is upon us now. Gentlemen, we are in the midst of battle. We heartily implore you to join us by withholding your countenance and support from the establishment of any new colleges. We would welcome a kind word of approval from medical associations and from private practitioners.

S. EAGON,	W. J. LANE,	W. R. WILSON,
E. L. THOMSON,	B. F. CHURCH,	S. G. THRUSTON,
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J. B. SMOOT,	J. O. McREYNOLDS.	

NO MORE MEDICAL COLLEGES WANTED.

From all over this country the cry goes up that no more medical colleges are wanted. A desire for the consolidation of existing schools is also apparent. They must be a venturesome crowd who will now advocate the launching of a new medical school. Let those whose ears long to hear the magical title of "Professor" hesitate before they incur the condemnation of their fellows.

Why should Iowa have seven medical colleges; why sixteen in Missouri; why twenty in Illinois? Why should Texas, which has two schools, want another? Recently an attempt has been made to found a medical college in Dallas, probably because the near-by city of Fort Worth has a medical school in full blast.

And yet the question is not so much the numerousness of schools as the ruinous competition, the scramble for students, the admission of men who are illiterate, the monetary qualification for the professorship, and the general hypocrisy too often found in those who direct the policy of the colleges. How often does it happen that the Secretary of a college is a man to whom the adjectives, "smooth," "foxy," "sly," and others of similar import, apply. Often he is selected for the express purpose of getting students—honorably if he can, dishonorably if he must; but students must be had at any price—even at the loss of all honor, decency and self-respect. How must the "Professors" feel if they ever stop to think whither they are guiding the grand old ship of medicine.

The destructive tendency of the day is evidenced by the existence of "fifty-cent hospitals," the abuse of medical charity by the schools of medicine, and the possession of professorships by the uncouth and illiterate. And yet not all is lost. The recent condemnation of the Missouri Medical College and the St. Louis Medical College, by the St. Louis Medical Society, the war which has been made on the cheap hospitals, and the voice of those independent medical journals which have the courage of their convictions, go to show that the medical profession is like a sleeping lion: rouse him from slumber and you hear his roar. We believe a better time will come soon. The history of the St. Louis Academy of Medical and Surgical Sciences shows that matters medical are improving.

Regardless of the voice of the *Medical Reflector*, sounding like the braying of a mule in the desert, we are of the opinion that it pays to have a mind of your own if you chance to be a medical editor. For few there be who like a straddler—especially if he be noted for the profuse and unlimited coinage of testimonials.

Any medical journal which shuts its eyes to the existing evils, or tries to curry favor with those who have incurred the condemnation of representative medical societies, cannot expect to retain the support of the better element of the profession.

DEATH OF DR. JAMES MOORES BALL, SENIOR.

This gentleman died at his home near Waterloo, Iowa, on August 26, 1897, at the age of eighty-five. Dr. Ball was a well-known surgeon. A suitable notice of his life will appear in our next issue.

OUR HISTORICAL ARTICLE.

We take pleasure in printing the historical article by Dr. Arthur E. Mink, upon Theodore Meynert. The second and concluding part of our article on the "Influence of XVI. and XVII. Century Philosophy on Medicine" will appear in our next issue. The TRI-STATE is the only medical journal in America which regularly contains a department devoted to the History of Medicine.

A STORY BY LYDSTON.

We are permitted to announce that Dr. G. Frank Lydston, of Chicago, the learned author of "Over the Hookah," will soon contribute to this magazine a new story with original illustrations. It will be published in this magazine exclusively. We believe our readers will appreciate a class of literature which departs from the hum-drum, technical lines of medical journalism.

DOCTOR BORCK'S REMINISCENCES.

Our readers will miss the usual article by Doctor Borck. We can assure them, however, that the series will be continued in our September issue and will run for several months to come. These articles are keenly appreciated by the older practitioners of St. Louis and vicinity, and especially by all who may have attended the College for Medical Practitioners—the first post-graduate medical school in America.

IN THE PROFESSIONAL EYE

FAYETTE CLAY EWING, M. D.

THE subject of this sketch was born May 28, 1862, in La Fourche Parish, La. He comes of pure American stock, and a long line of physicians.

Dr. Ewing is a son of the late Dr. F. C. Ewing, and through him is descended from General Robert Ewing of the Revolution. The four immediate maternal grandfathers were New England physicians. He married in 1885, Miss MacDonald, of Washington City, and has four sons. Dr. Ewing was educated at the University of the South, and at the University of Mississippi. He attended medical lectures at Tulane University and Jefferson, graduating at the latter institution in 1884, and locating in Washington City in 1885. After determining to make a specialty of the throat, nose, and ear, he took the course of the New York Polyclinic, and the Metropolitan Throat and Ear Hospital, and attended the course in diseases of the throat, nose and ear at the London Post-Graduate School



FAYETTE CLAY EWING, M. D.

in 1893. Dr. Ewing served six months as senior clinical assistant in the Central London Throat, Nose, and Ear Hospital, assisting Lennox Browne, and Dundas Grant. Later, he was appointed to a similar position in the London Throat Hospital, as assistant to Edward Woakes and Edward Law. After leaving London he attended operative courses in Vienna. He was one of the delegates from the American Medical Association to the eleventh International Medical Congress, Rome, 1894, and is a fellow of the British Rhinological, Laryngological and Otological Association, being one of two Americans having that honor. After returning to America he located in St. Louis, seeking a larger field for special work. Dr. Ewing is a polished writer and contributes liberally to the journals. He is a man of varied reading, who believes that general literary culture is not inconsistent with high professional attainment and success.

THE SPIRIT OF BEAUTY.

By WILLIAM COLBY COOPER, of Cleves, Ohio.

From Dr. Cooper's recently published volume of Essays, Sketches and Poems, entitled: "Tethered Truants."

Oh, what is the spirit of beauty I
cried

In a passionate, puzzled despair,
As I gazed in the skies on a sweet
eventide,

And thought of the mysteries
there.

That instant a fragrance fell
over the night,

And an essence ineffably sweet
Absorbed me and flashed out in
wilderling flight

Toward farness's furthest re-
treat.



Out, out through vast vistas, in
shimmering haze

Of scintillant star-dust, I
whirled;

Through radiant ripples of astrean
rays,

And past pulsing world after
world.

Past galaxies gemmed with bright
orbs, as I spun

Like light through ethereal seas;
Past ebulant, emerald sun after
sun

And past the far "Sweet
Pleiades."

On, on, out in planet-isled space
 till, at last
 A crystalline bound burst in
 sight
 With star-circled portal, high-
 vaulted and vast,
 All glowing with iridal light.

And I caught, in the instant the
 gates sprang ajar,
 The glimpse of a glittering
 throng,
 And there fell on my hearing from
 hosts, near and far,
 The refrain of a triumphant
 song.

'Twill haunt me forever, through
 pleasure and pain—
 That song from Away and
 Above,
 With its sweet, and its solemn and
 sacred refrain:
The Spirit of Beauty is Love.

REPORT OF THE FORTIETH ANNUAL MEETING
 OF THE
 Missouri State Medical Association,

HELD AT

Century Theater Building, St. Louis, May 18, 19 and 20, 1897.

[CONTINUED FROM JULY ISSUE.]

Paper—"The Sixth Nerve and Its Diseases"—was read by Dr. J. H. Thompson, of Kansas City. He discussed the anatomy and physiology of the sixth nerve, giving both the superficial and deep origin. He told how, from the anatomical arrangement, hæmorrhage into the medulla or pons would give rise to very grave symptoms. He said: This nerve is more frequently paralyzed than any other. Trauma is a very frequent cause of disease of this nerve. May have as a result of trauma epilepsy, locomotor ataxia and multiple sclerosis. He cited a case showing the involvement of this nerve as a direct result of trauma: Patient was struck on the head with sufficient force to knock him down. On regaining consciousness he complained of pain in the head; the external muscles of the eye were paralyzed; enormous quantities of urine of abnormal specific gravity, no albumen and no casts, were voided. The lesion of ataxia is permanent, but in the beginning is only transitory and then becomes fixed. Rheumatic neuritis is a very important disease; there is usually a history of pain in the orbit. A cure for this condition consists of the proper anti-rheumatic remedies. Transitory ocular palsy is very important and should always be considered a very serious condition.

Paper—"Salpingitis Vegetans Perforativa; Adenoma Salpingitis"—was read by Dr. J. B. Ross, of St. Louis. He entered into the minute his-

tology of the Fallopian tubes; also gave their physiology and the pathological conditions often met. He said that cases of salpingitis vegetans perforativa are very rare. When these growths do exist we are very apt to overlook them when removing the tubes. He cited cases that had been observed by him; also cases that he had in his own practice.

Paper—"The Use of the X-Rays as a Means of Diagnosis"—was read by Dr. C. C. Morris, of St. Louis. He said: In looking backward over the past few years we note great advancement. Were I to write of all the new discoveries made for the safety and convenience of man, I would have enough material to fill many large volumes. I only wish to speak of the discovery that has excited the most comment—the discovery of Prof. Roentgen. It seems that in this the climax has been reached. I believe that as a means of diagnosis it will be of great use in the future, but at the present time it is limited and unsatisfactory, and is only of value in locating phosphatic deposits, renal calculi and metallic foreign bodies. The only exception to the locating of foreign metallic bodies is in the cranium, on account of its opacity. He cited several cases where foreign bodies were located by means of the X-rays, thus enabling the surgeon to relieve conditions that otherwise never could have been overcome had he not had this means of diagnosis. He gave one instance in which the back had been crippled for seven years on account of a gun-shot. By means of the X-rays the bullet was located and removed by a surgical operation. In a case of a coal miner whose back was broken in a coal slide, the fractured vertebræ were located in the dorsal region; a successful operation was performed and the patient was very much relieved. He mentioned another case in which he was able to make a diagnosis of impacted fracture of the femur. This means of diagnosis is destined to be of great use from a medico-legal standpoint where there is a "bone of contention," and the physician is legally liable and may be held to a strict account, both in the sick-room and in courts of justice. Employ whenever possible the X-rays as a means of diagnosis and you will surely be on the winning side. The torch of knowledge should be passed on to others, and in this way we may make long strides toward the perfecting of methods by which the X-rays may be of practical use as a means of diagnosis.

Paper was read on "Gastrotomy for Foreign Bodies; Report of a Case; Presentation of Foreign Bodies Removed from the Stomach," by Dr. A. H. Meisenbach, of St. Louis. He said: The indications for gastrotomy are the presence of a foreign body that cannot pass through the intestines, and the symptoms and condition of the patient. There may be foreign bodies in the stomach for a long time, and yet no disturbance to the patient. Long bodies, such as knives, forks, etc., usually give rise to symptoms on account of their size and form. Small bodies will collect and finally produce adhesions or perforations. There may be catarrhal symptoms and shifting pains caused by posture of the patient. The patient may have hæmorrhage, emesis and become exhausted. As soon as a diagnosis of foreign bodies is made they should be removed. He cited a case of a man 22 years old; of a nervous temperament; father and mother living. Patient had received a good education and while at school had learned the art of glass-eating. He finally swallowed nails, screws, staples, etc. Since 1884 he had been giving exhibitions in this art. He had never

swallowed tacks. Up to 1897 he had no trouble. He gave exhibitions on March 15th, and on the 16th of March felt a lump in the stomach. He came to St. Louis. At this time he had pain in the stomach, but no other pains. Temperature was normal. He then gave the manner by which he arrived at a diagnosis by exclusion. Drs. Lemen, Crandall and Bond saw the case with him. He tried the X-rays, placing the instrument twelve inches away from the patient. The exposure was only one hour in duration. He located the mass in the region of the umbilicus. Operated on the 7th of April at the Rebecca Hospital. He made an incision in the median line, extending from the ensiform cartilage to the umbilicus. He delivered the stomach out of the abdomen and made an incision long enough to admit the bone forceps and delivered the greater part of the contents of the stomach. He made the incision larger and introduced the hand and took all the bodies out of the stomach, then swept the hand all around in the stomach, including the cardiac and pyloric end, and then closed up the wound. The patient rallied and did well until the fourth day, when the temperature ran high and he began to cough. On examination of the lungs he found consolidation; there was also the characteristic pulse and sputum of pneumonia. On the tenth day he removed the stitches, and on the eleventh day the wound was only superficial. About the first of May all symptoms referable to complication on account of pneumonia were relieved, also union of the wound had taken place. This is the first case in this country in which the X-rays were successfully used as a means of diagnosis. Sometimes the X-rays have a bad result on the patient. We must make a larger instrument with a less exposure at a greater distance. Have not been able to make a clear picture below the thorax; neither have we been able to explore the hip. The differentiation of tissue is out of the question. Neither can hypertrophies of the heart or other organs be differentiated as yet. He exhibited specimens removed in the case of gastrotomy.

Dr. Morris, in his closing remarks, said: What Dr. Meisenbach said is true of the sheltered parts. The instruments we now have are insufficient; it will require a more powerful instrument to penetrate the deeper structures of the body. An instrument not directly connected with an electric light is of no great use. In the case of the hip referred to, the exposure was only made twenty minutes, and there was only a faint outline. He intends to work on until he succeeds in getting good photographs. Cannot get a picture of the heart at rest, this remains for the future and some energetic discoverer to bring to perfection. The X-rays have been brought to their present degree of perfection in the past two years.

Paper—"Report of the Committee on Pediatrics"—was read by Dr. W. E. Saunders, chairman, St. Louis. He said: Within the past year there has been great improvement in the treatment of diphtheria by the antitoxin serum. In this disease the serum treatment has triumphed, and any one who has once used it will never renounce it. Sudden deaths, apparently due to the injection of antitoxin, have been recorded, but it has not been demonstrated as being the cause. In some cases death is due from vomited food, and in some from shock or the entrance of air. Should use concentrated serum and a very small needle. Have had the best results from injection in the rectum or arm. He gives by the mouth when the

prophylactic action is required. He said: It is necessary to keep up a normal diet which will supply the required salts, nitrogenous foods, etc. Rennet and whey should receive more abundant recognition as a food than they do to-day. He said: There is some difference in the chemical constituents of the milk of the mother and the cow, and told how the cow's milk could be made very much like human. He spoke of the use of thyroid extract in stunted growth, and of good results following its use.

DISCUSSION OF PAPER ON PEDIATRICS.

Dr. Love said: Dr. Saunders has done faithful, energetic work along the line of pediatrics. I am surprised that this branch of medicine is not more interesting to the bulk of the profession. Various branches of surgery are interesting, but I insist there is no subject which ought to appeal to the earnest, conscientious physician more than that which pertains to the health and life of the child from the very beginning of its existence. The question of infant feeding is the very key-note of pediatrics, etc.

Dr. A. B. Miller requested Dr. Saunders to explain his method of obtaining sterilized milk.

Dr. Saunders, in his closing remarks, said, in answer to Dr. Miller: Milk can be obtained perfectly sterile from the cow by rejecting the first portion which washes out the lacteal ducts and then keep the remainder of the milk free from atmospheric influences. Milk can be obtained perfectly free from germs and can be preserved for a long time. Fractional sterilizing or pasteurizing cannot be relied upon. Some germs even resist a temperature of 220° F. The cholera infantum bacillus will resist a very high temperature for over four hours. Absolute cleanliness with the milk and then cooling the milk to a very low degree—so low that bacteria will perish—is the solution of the problem.

On motion convention was adjourned.

WEDNESDAY MORNING SESSION, MAY 19TH.

Meeting called to order by the president at 10:20 A. M.

Miscellaneous business transacted.

Paper—"The Report of the Committee on Obstetrics"—was read by Dr. F. D. Mooney, of St. Louis. He said: The treatment for extra-uterine pregnancy is surgical. Can only relieve by operative measures. Blood, when found in the peritoneal cavity, need not cause any great alarm. The peritoneum can dispose of a certain amount of blood without any symptoms, except a rise in temperature for a few days. In cases of excessive loss of blood from any cause, it is best to inject a normal salt solution in sufficient quantity to replace blood lost. He said: There have been a great many methods devised for the treatment of eclampsia, especially preventive measures. The pregnant woman should be examined and urine tested at least once every month. There is probably no condition in which less has been done and in which more could be done than in the treatment of eclampsia. The safety of the puerperal woman should not be left in the hands of the midwife or careless physician. Venesection has fallen somewhat into disuse, yet some of our best physicians have not discarded it. In the plethoric it is a good plan to open a vein and take out a large amount of blood, and then inject a normal salt solution in sufficient quan-

tity to supply the normal amount of blood. He does not consider vaginal douches as a routine practice after confinement safe. Those who observe asepsis are better physicians than those who employ antiseptics. The use of the curette, even in the hands of the most skillful, breaks down the lymphatics and injures the endometrium. Instead of using the curette, I substitute my fingers, and I consider them the best instrument in the world. Instead of using the douche of water, use peroxide of hydrogen, close the canal and have drainage. The serum therapy is destined to be classed with many other remedies as only visionary. Labor is unnatural after ventral fixation of the uterus has been made, and in many of these cases it is necessary to make Cæsarian section if the woman becomes pregnant. I usually prefer Cæsarian section to symphysiotomy. It is surprising to note the many calls the physician has to bring on an abortion. He said: I am often requested by ministers of the gospel to bring on an abortion.

DISCUSSION OF PAPER ON OBSTETRICS.

Dr. Matthews said: Symphysiotomy is not practical to the general practitioner, who must act in the capacity of obstetrician whenever called upon. The operation is more difficult and more care must be taken in the technique than in Cæsarian section. When at the bedside it is hard to decide as to the best operative measure to employ for the relief of the mother and the delivery of the child. He said: I endorse all said on eclampsia, cause and treatment.

Dr. Hughes said: Puerperal eclampsia is a spasmodic toxic neurosis, and in order to prevent this condition the central nervous system must be protected. He came to this conclusion early in his practice, and claimed to be the first one to introduce the use of chloral hydrate in the treatment. He gives a hypodermic injection of morphine and then an injection of chloral hydrate per rectum. Patients thus affected are usually of a nervous temperament.

Dr. Bauduy said he considers puerperal convulsions a neurosis. There are many cases of convulsions in which no albumen can be found. The most satisfactory treatment is the administration of chloroform or chloral hydrate; these remedies act by reducing the excitability of the spinal cord.

Dr. Hypes said: I cannot pass what Dr. Matthews said about the general practitioner not being able to diagnose between conditions that do and those that do not require operative measures. Every physician should be able to diagnose by use of the pleximeter the exact measurements of the pelvis, and then by use of the hands and external measurements can assure themselves of the conditions, whether normal or abnormal. The puerperal woman should be in the hands of the physician from the beginning of her pregnancy. Excretions, especially from the kidney, should be watched. Eclampsia is not a neurosis. I just asked Dr. Bauduy the meaning of the word neurosis, and this is the substance of his answer: "It is a disease that we do not know anything about." Eclampsia then is a neurosis because some of the physicians do not know anything about it. This accounts for the discussion of some of these honorable gentlemen.

Dr. Mayfield said: The neurologist should be gotten nearer to and we would have better results with our patients. The curette in the hands of

the physician who understands its use is not dangerous. He had never known of a perforation through the uterus into the peritoneal cavity to take place. He said: I challenge what was said in one of the papers about ministers of the gospel asking physicians to cause abortion. He said: We owe a great deal to them. It is through their efforts that we have our hospitals, churches, and a great many institutions of learning. He requested that the part of Dr. Mooney's paper in which he made the statement about ministers be struck out before his paper goes on record. He said: I do not think that statement in regard to ministers true.

Dr. Mooney, in closing, said: I will not retract what I said about preachers, but will repeat my charges. I will state, further, that I have in my possession the model of an instrument devised by a minister for the purpose of causing abortions, and he has applied for a patent on the same. He said he did not think the curette could be used for the purpose of removing placental tissue and not injure granulation tissue springing up.

Paper—on "The General Practitioner and the Singer"—was read by Dr. Hanau W. Loeb, of St. Louis. He said: The lungs and muscles of respiration must be well developed and under perfect control of the singer. The physician attends to the physical well-being of the pupil, while the teacher directs his efforts to simply the development of the voice. The teacher should master the vocation of the physician, and the physician that of the teacher. A great many people have not the slightest idea of the source of the normal voice; they have vague ideas that the sound comes somewhere from the head or lungs. Atmospheric influences have a very prejudicial result on the singer. When mouth-breathing is practiced, the heat and moisture are taken from the larynx and pharynx, to their great detriment. The hygienic physiological function of the nose is not understood by the majority of people. Mouth-breathing in children should be corrected ten years before vocal instruction is commenced. Hypertrophic rhinitis, rhinopharyngeal fibromata, and other growths of the nose, are responsible for mouth-breathing. Teachers often recommend mouth-breathing on the ground that often the singer must take a breath so quick that he cannot breathe through the nose. Few teachers appreciate the value of the lower chest-breathing in singing. The dress of the students has much to do with the progress they make. The corset should not be worn when practicing. Cold plunge baths are to be recommended. The singer should be in good health, for one whose system is undermined by disease cannot be a natural singer. Regime—First, nasal respiration is imperative, and all interference should be removed. Second, inferior lung-respiration should be employed, and the physician should pay strict attention to the habits of the singer.

Paper—on "Suicide"—was read by Dr. C. H. Hughes, of St. Louis. He said: I know that my views will clash with current opinion on the subject, and I expect criticism from various sources, but if given in kindness it will be all right. There are circumstances, times and places when suicide is commendable and is a godly heroism. There are times when the voice of God approves of self-destruction. In the Book of books it is recorded that, after the betrayal, Judas went out and hanged himself. This was commendable, and no censure is recorded in Holy Writ. Every man

who lives is not in duty bound to exist until the appointed time, miserable and unhappy throughout life. Suicide should be regarded as a pruning-knife which cuts off the moral weaklings. The human race would be better off if there were more suicides. The average suicide does a good act for himself, and should be regarded as a public benefactor. To the theologian, suicide is always a sin; to the philosopher it may appear as selfishness; to the physician it may appear as to the philosopher and divine, but also as a benediction to mankind.

On motion, convention was adjourned.

AFTERNOON SESSION, 2:30 P. M.

Announcements made and miscellaneous business transacted.

Paper—"Report of the Committee on Gynecology"—was read by Dr. H. Crowell, of Kansas City. He said: We lay claims to great strides made lately in gynecology, yet we must not lose sight of the fact that the improved environment under which we labor was made possible by those who came before us and labored just as earnestly, yet without the brilliant results we now enjoy. Their attainments under adverse circumstances were wonderful. He spoke of the aseptic surgical operations of to-day and the success met from different methods of operating, especially the methods for removal of the ovaries and tubes. Ligating the blood supply of the uterus, for checking growths has not appealed to the gynecologist generally, and it does not appear to be worthy of notice in this progressive era. It is now well proven that cancer is contagious, and it should be treated with greater care. Total extirpation is the only method to be practiced. All surrounding lymphatics should be removed, and this method is not attended with so much danger as the "let alone" treatment. There has been as much advancement in surgical gynecology as in any other branch of surgery.

DISCUSSION OF PAPER ON GYNECOLOGY.

Dr. Glasgow said that in ovariectomy he prefers to operate through the vagina, as there is less danger to life, less shock and no hernia; yet there are cases in which satisfactory work cannot be done through the vagina. He said: In the future this will be the chosen route in nearly all cases. He spoke of Alexander's method of shortening the round ligament. Ventral fixation is unsatisfactory. He said: There has been some work done during the past year investigating micro-organisms found in the vagina. There has been found a bacillus here that inhibits the growth of all bacilli. This teaches us that if the douche is used too freely we may remove some of the safeguards placed there for a purpose.

By request, Dr. Murphy, from Chicago, discussed the subject of gynecology. He said: The question to-day is in what class of cases shall we select the vaginal and in what the abdominal route. There are three great causes of infection: (1) following labor; (2) miscarriages; (3) gonorrhœa. In the first two classes we have the lymphatics of the pelvic organs infected. This infection takes place from the vagina, uterus, tubes or broad ligament. In gonorrhœa of the pelvis a tube is rarely infected. We have the same condition in the female as in the male, viz.: The formation of a stricture, which occurs at the most constricted portion, which is

at the uterine end. You must not drain this through the vagina, as you have a secreting mucous membrane which is closed at the uterine end and at the fimbriated end and in such a case there is retention and the re-formation of pus. The first two conditions demand vaginal drainage, the last abdominal.

Dr. Crowell, in closing, said: I admit my paper did not cover all the progress made in gynecology; it was impossible in the time I had. Pus cases should be drained through the vagina or be operated on through the abdomen. In cases where there is a liability that pus may escape, it is best to make an abdominal operation, as the other is extremely hazardous; but in making total extirpation, the vaginal route is the preferable one.

Paper—"Alcoholism and Its Treatment"—was read by Dr. J. K. Bauduy. He said: I will give results of treatment of 1129 cases of alcoholism. These cases were real and not speculative. This includes cases treated in the St. Vincent's Hospital from 1865 to 1888, and does not include cases treated in army or private practice. Wood reports 1241 in his practice, with a mortality of one case in ten. My mortality was one case in eighty-one. Alcoholism is a disease of the nervous system, caused by the excessive use of spirituous liquors. It is characterized by insomnia, muscular weakness, delirium, nausea, vomiting and epilepsy. Very few die in the first attack, but each successive attack is more dangerous, as there is a greater amount of organic disease. If you dissect out a nerve or bundle of nerves and place them in alcohol, you will find they will no longer conduct nerve force. The weaker the alcohol, the less is the nerve affected. Alcohol in the amount taken by these patients is not a stimulant, but a powerful narcotic sedative. Paralysis of the vaso-motor system induces hyperæmia of the nervous system, and especially of the brain. The treatment consists in the use of calomel, lime water and milk, beef essence with capsicum. Bromides are given to prevent convulsions and reduce reflex excitability and vaso-motor paralysis, one of the most common causes of death. Sulphonal has been given in moderate doses.

Paper—"The Nervous Dyspnœa of Bright's Disease"—was read by Dr. Robert F. Brooks, of Carthage. He said: The urine may be scanty or absent during any case of chronic Bright's disease; it is not the amount of urine, but the amount of albumen that is of great importance. The amount of albumen may be varied by the amount of certain kinds of food ingested. He cited a number of cases. One in which the dyspnœa was so marked that Bright's disease was not suspected until an examination was made of the urine.

DISCUSSION OF PAPER ON DYSPNŒA OF CHRONIC BRIGHT'S DISEASE.

Dr. Wainright said: I believe that the dyspnœa in the cases reported by Dr. Brooks was not due to renal troubles alone, but to trouble with the heart. In all diseases of the kidney, of long standing, there will also be disease of the heart. These conditions lead to sclerosis of the blood vessels and lead to hypertrophy of the heart. The amount of urine should be measured each day and the amount of urea ascertained before we can feel safe about our patients.

Dr. Punton discussed the paper on suicide and said: I think Dr. Hughes took too liberal a view when he excused cases of suicide on the ground of duty and saying the public is well rid of them. We may, per-

haps, excuse a great many on a bad neuropathic heredity, for, if you trace the case back you will find that he was prone to suicide from the day he was born. A great many cases of suicide are wholly unwarranted. Some men believe that the man who commits suicide is insane. If this is the case, we lose a great deal of time in trying to screen these men from the gallows.

Paper—"Tracheotomy in Diphtheria in Conjunction with Antitoxin"—was read by Dr. E. Von Quast, of Kansas City. He said: Of all the diseases of childhood membranous croup is most dreaded. The question as to whether or not membranous croup and diphtheria are identical was for many years a bone of contention in our profession. There were a great many discussions and a great deal was written on the subject. Bacteriology has thrown light on the subject, and it is now proven that in all cases the Klebs-Loeffler bacillus is found in membranous croup and diphtheria. It is to be hoped that soon no cards with membranous croup will be seen, but the word will be diphtheria every time. A great many cases of diphtheria are not reported, but are treated as sore throat; sometimes they are not reported from fear of quarantine. There were a great many remedies tried, but the death rate was enormous, even after we began performing tracheotomy. Antitoxin has been given a thorough trial and it now has its place in therapeutics. He said: I believe the time will come when a refusal to use the antitoxin in cases of diphtheria will be considered criminal. Antitoxin is not a cure-all and should be given early in the disease. To have good results it must be given early and in large doses, and be careful to keep the membranes from entering the trachea. He has performed many tracheotomies within the past few months. He cited many cases in which he had used the antitoxin in conjunction with tracheotomy to great advantage,

Paper—"The Use of Antitoxin in Diphtheria"—was read by Dr. E. C. Evans, of Sedalia. He gave the history of eighteen cases of diphtheria in which he had used the antitoxin without a single death. In one case he made a tracheotomy. He has been treating diphtheria for a long time and never had a case recover in which the nose and throat were involved before he used the antitoxin. He said: I do not now fear any case if called early and the antitoxin is given in large quantity. All so-called cases of membranous croup are diphtheria and should be so treated with antitoxin. He considers antitoxin as nearly a specific in diphtheria as quinine in malaria. Most of the fatalities are due to delayed administration, and success depends on the purity of the serum. It is the greatest discovery of the nineteenth century.

Convention adjourned.

WEDNESDAY EVENING—SPECIAL IN HONOR OF THE ILLINOIS STATE
MEDICAL ASSOCIATION.

Invocation by Rev. Snyder of the Church of the Messiah.

Music by the orchestra.

President Duncan, who was to deliver the Annual Address, was introduced by President Carr.

President Duncan said: I cordially welcome the members of the Illinois Association, the members of the Missouri Association, and all others present. He said: I have chosen as the subject of my address "The Med-

ical Man as a Citizen and a Business Man." As a rule, doctors are not expected to take interest in anything not pertaining to medicine, but this is a mistake. In the first place, the doctor is to blame, as he almost gives up his citizenship; in the second place, the people, since he thus resigns his position, have come to look upon him as only a doctor. It is his duty to take interest in the affairs of State. I would discountenance the doctor who makes stump speeches, but I have long felt that he has his place at the polls and that he should exercise his citizenship in the daily walks of life. In referring to the late action of Governor Stephens in removing the regulars from the asylum at Fulton, he said: It is an insult to the members of the medical profession. A competent governor is the State's safety in her hour of distress, but we are utterly helpless in the hands of one who is unwilling to recognize the difference between massage and mesmerism. I cast no slur on the school of homœopathy, no matter how much I differ from them in practice. In the Insane Asylum, at Fulton, there are seven hundred inmates, and in February, 1897, there were not three per cent. of them followers of homœopathy, yet the Governor has seen fit, without cause, to remove two competent men in order that he might gratify himself and please the homœopathic physicians. I appeal to the friends of the insane at Fulton and to the citizens of the State of Missouri if it is not cruel for the Governor to place over these people the homœopaths when they could not help themselves. He said, referring again to the "Medical Man as a Citizen": I do not think it detracts from professional honor to show that we take interest in something besides medicine. I do not think the man who confines himself exclusively to one branch of business and shuts off everything else is so efficient in his profession as the man who takes interest in outside affairs.

Paper—"The Progress of Medicine"—was read by Dr. R. J. Sloan, of Kansas City. He said: Investigations in the laboratories of the chemist, physiologist and pathologist furnish data upon which are based new methods of diagnosis, prophylaxis and therapeutics. He then spoke of the immunizing agent, antitoxin, in the treatment of diphtheria and tuberculosis. He said: Tuberculosis pure is self-limited, but when complicated with a mixed infection it becomes very malignant. He spoke of the discovery of Laveran of the plasmodium of malaria, and spoke of the means by which a diagnosis could be made between leukæmia, chlorosis and pernicious anæmia, by a microscopical examination of the hæmoglobin. He referred to Widal's serum test in the diagnosis of typhoid fever; also referred to Koch's new tuberculin. He spoke of the tests made by Bremer and Williams for diabetes, by an examination of the blood. He believes that a large number of diseases usually considered functional are due to auto-intoxication. He spoke of the Roentgen rays, and said so far this discovery is of no use to the bacteriologist, but he said with improved apparatus it will be of practical use.

DISCUSSION OF PAPER ON PROGRESS OF MEDICINE.

Dr. Hugo Summa said: I endorse all that Dr. Sloan has said on this subject. The great advances made in surgery are due to the fact that the surgeon simply carries out therapeutic measures. There are two groups of diseases demanding our attention, and these are the infectious diseases and

malignant tumors. The cause of malignant tumors and a number of specific diseases is practically unsolved, notwithstanding persistent efforts made in this direction. Bacteriology has settled the cause of a great many diseases, yet the cause of epidemics is unsettled. The improvement of instruments is of great use, and it is now possible to make a correct diagnosis in ninety-five cases out of a hundred. Puncture of the spinal canal is now of great importance in the diagnosis of meningitis, and it is possible to demonstrate as to whether the streptococcus or the staphylococcus is the cause.

Paper—"Progress of Surgery"—was read by Dr. A. W. McAlester, of Columbia. He said: There has been great advancement made in surgery; also in the manufacture of instruments. The city physician, with his many advantages, cannot appreciate the disadvantages under which his country cousin labors. Since the laboratory has demonstrated the habitat of bacteria, how different the treatment of disease! In speaking of the Roentgen rays he said: Since the action of the rays is sometimes so deleterious to the outside of the body, may we not look for destruction on the inner parts; may the protoplasm not be affected? Thompson was led to the conclusion that not all of the rays are of the same product, and the experiments of Porter show that the rays are not uniform, but consist of two different varieties. We formerly considered wounds of the liver fatal, but now a large portion can be excised and yet the good work will go on. The general practitioner finds that he can do little in obstruction of the gall duct, and he turns to the surgeon for relief. The red blood corpuscle becomes disintegrated in obstruction of the gall duct, and an early operation is necessary. We now think that gall stones are formed from the blood, and the colon bacillus often forms a nucleus for the formation of a gall stone. He called the attention of the surgeon and general practitioner to the necessity of making an early exploratory incision, taking into consideration the condition of the patient locally and generally.

DISCUSSION OF PAPER "THE PROGRESS OF SURGERY," BY DR. MUDD.

Dr. Mudd said: The X-rays are of great interest to the profession, but especially so to the surgeon. Through this means we have been able to locate foreign substances; the liver, lungs and heart have been fairly well outlined. Cases have been reported in which a stone was found in the kidney. They are of interest from a medico-legal standpoint; they have been of use in diagnosing ununited fractures of the bones. Flexions in the common and cystic duct are often the cause of obstruction. Any pressure upon these ducts may cause great dilatation and a cystic tumor will be the result. It is safer to open the common duct than to bruise it by trying to crush a stone.

On motion, meeting was adjourned.

MORNING SESSION, MAY 20.

Reports of various committees. Miscellaneous business.

Paper—"Non-Medical Treatment of Chronic Constipation"—was read by Dr. S. G. Gant, of Kansas City. He first gave the causes of chronic constipation, which are: (1) Mechanical obstruction, where the feces are prevented from passing along the intestinal tract. (2) Defective peristal-

sis, caused by irregular habits of living and not paying attention to the calls of nature; this causes reversed peristalsis and the feces go back and accumulate and the pressure upon the nerves of the bowel causes paresis. (3) Deficiency of secretions causes diminished peristalsis; the causes of deficiency of secretion are diabetes, melancholia, insanity and old age.

His treatment consists in frequently dilating the sphincter muscle, using massage of the abdomen with general massage after copious injections of hot water, electricity, go to stool at regular intervals, correct diet, drink an abundance of water and eat fresh fruit, cold baths every morning followed by thorough rubbing, dress cool in summer and warm in winter, be temperate in all things. Dilatation is made in two ways: immediate and gradual. In using immediate give an anæsthetic and stretch until there is no resistance in the muscle—use the thumbs—they are better than any dilator. In the second, stretch gradually a little at a seance; it is better to do too little at the first sitting than too much. Massage the liver and small intestines when there is diminished intestinal secretion. If the circulation is poor, give general massage. Out of 300 cases treated 176 were cured; 72 marked improvement; 20 slight improvement; 32 no improvement.

Paper—"A Case of Strangulated Hernia with Resection of the Bowel"—was read by Dr. H. C. Dalton, of St. Louis. Dr. Dalton said: This patient was suffering great pain in the abdomen; had a history of long standing hernia; could not be reduced; the man was taken to the hospital, and on cutting down I found a stinking intestine. He made an incision at the internal abdominal ring and pulled out the intestine and poured in hot water. He cut out the infected part of the intestine and sutured, using the Lembert. He dressed it with iodoform gauze, leaving drainage, and then dressed the abdominal wound. Patient recovered in three weeks. He said the good results were due to the methods and technique of the operation.

DISCUSSION OF THE PAPER.

Dr. Von Quast asked Dr. Dalton how long before he allows food and drink after such an operation. This operation was an ideal one.

Dr. Dalton said, in answer to the question: I give the patient no food for four days, but I give injections of water which relieve thirst.

Dr. Hall said that in a child the nurse or mother can dilate the sphincter, and in his experience many cases of congenital narrowing have been cured. He said a young practitioner gave him a cure for constipation, which consists in giving glycerine which causes peristalsis, and chloroform which relaxes the sphincter.

The society proceeded to the election of President and selecting a place for the next annual meeting.

Dr. Geiger, of St. Joseph, was chosen president, and Excelsior Springs selected as the next place of meeting.

Appointed to Board of Health.—Governor Stephens has appointed as members of the State Board of Health of Missouri, for terms of four years each from April 18, 1897: Dr. L. C. McElwee, St. Louis; Dr. O. A. Williams, Versailles; Dr. J. T. McClanahan, Boonville; Dr. Sam C. James, Kansas City.

HISTORICAL SKETCH.

THEODOR MEYNERT.

By ARTHUR E. MINK, M. D., of St. Louis,

Professor of Mental and Nervous Diseases, College of Physicians and Surgeons; Consulting Neurologist to the Baptist and Woman's Hospitals; Formerly Physician to the New York City and Kings County Insane Asylums.

ON May 31, 1892, by an untimely death, science was robbed of one of its noblest exponents, a man who has indelibly stamped his name upon the history of his profession by his pioneer researches upon modern brain anatomy and by his contributions to scientific psychiatry.

Theodor Meynert was born in Dresden, June 15, 1833. His father, Dr. Hermann Meynert, was an eminent historian and litterateur, and his mother was a gifted songstress. Three years after, his parents removed to the city which was destined to be the future field of their son's activity—Vienna. The education of his earlier years was conducted by his parents, and he soon manifested marked talent for literature; Shakespeare being his particular favorite. Meynert's early training peculiarly fitted him for the destiny which later called him to deal with the grandest problems of medical science. In 1861 he received his degree of doctor, and later, in 1865, was appointed docent to the University of Vienna and at the same time assistant physician to the Lower Austrian Insane Asylum.

His talents soon attracted the attention of Rokitansky, and he shortly became prosector to the great pathological anatomist, who incited him to some researches upon the pathological anatomy of the pons. Nevertheless, the first work of his which attracted wide attention was his chapter upon the anatomy of the brain, in Leidesdorf's Manual of Mental Diseases in 1865. In 1868 appeared his epoch-making work "Ueber den Bau der Grosshirnrinde und seine örtlichen Verschiedenheiten."

In this work Meynert gives us for the first time a scientific histology of the cerebral cortex, and was the first to point out the anatomical and consequently functional differences of the apparently homogeneous cortex.

He distinguished the following types of the cerebral cortex: the five strata types common to the convexity and gyrus fornicatus; and as deviations of this, the types of the occipital cortex, the type of the Sylvian fossa, the Ammon's horn formation, and the type of the bulbus olfactorius. He was also the first to make an estimate of the number of nerve cells in the cerebral cortex, which he put at about 800,000,000.

In 1869, in his "Studien über die Bedeutung des Zweifachen Rückenmarksprunges aus dem Grosshirn," he showed that there was a direct relation between the size of the cerebral lobes and the development of the crus cerebri and its ganglia; man possessing the largest lobes and consequently the largest crura cerebri. On the contrary, the smaller the cerebral lobes are in an animal, the larger the tegmentum and its ganglia.

In 1870 his article upon the Brain of Mammals appeared in Stricker's Handbook of Histology.

For years it remained the authoritative article upon this subject. It was Meynert that gave the name of "association fibers" to the fibræ proprie, anterior commissure, uncinata and arcuate fasciculus, cingulum, corpus callosum, etc., and pointed out the part they played in the psychological mechanism.

By his theory of the projection of the sensory surfaces upon the cerebral cortex and thence upon the muscular system, he paved the way for the subsequent localization of cerebral functions.

His germinal ideas in this domain have recently been elaborated by Flechsig with the most brilliant results.

Meynert everywhere and always insists that sensation is the only property of the cortical cells, and that what we call voluntary movements are due to the perception or memory of sensations of innervation or sensations which accompanied muscular adjustments.

Meynert's studies have had a profound influence upon every department of brain pathology as well as modern psychology. Notwithstanding his restless activity in encephalotomy, he soon addressed himself to another task—the advancement of psychiatry as the science of diseases of the fore-brain, based upon its structure, functions and nutrition. Meynert's endeavors in this direction will form one of the most interesting chapters in the history of medicine, for incomplete as his labors remain, they yet remind us of a Titan struggling with gigantic obstacles. In 1876 his "Skizzen ueber Umfang und Wissenschaftliche Anordnung der Klinischen Psychiatrie" was published, in which he gives a preliminary sketch of aims, methods and subject matter proper, of scientific psychiatry.

Two years later appeared his "Ueber Fortschritte im Verständniss der Krankhaften Psychischen Gehirnzustände," which he closed with these words: "This localizing tendency of psychiatric investigation is analogous to the development of all clinical disciplines, since the diagnosis first seeks for the diseased organ and only later concerns itself with the anatomical processes lying beneath. Localization is a station for modern psychiatry, on the way to a clinical science." In 1884 the first part of his great work "Lehrbuch der Psychiatrie" appeared, which unfortunately remains incomplete.

This work contains a mine of information on the subject of the anatomy and physiology of the brain. In 1890 his "Klinische Vorlesungen über Psychiatrie" appeared. This work supplements in a certain way his "Lehrbuch," which he never lived to complete. This work, which, like all of Meynert's productions, is written in a very laborious style, contains a wealth of material and everywhere bears the stamp of his great genius. In it he establishes the syndrome of amentia or confusional insanity, which includes, according to him, an acute delusional insanity and part of what other authors would call mania and melancholia.

He holds to the classical form of paranoia, and gives an interesting description of the pathogenesis of this interesting mental disease. He ascribes to bulbar hyperesthesia the chief part in the production of the disease. His chapter on the brain weights of different forms of insanity, is a most interesting one, especially in dealing with paranoia, in which he shows that the fore-brain suffers no loss in weight.

His chapters upon mania and melancholia are very interesting, and especially so are his ideas regarding anemia and hyperemia in relation to melancholia and mania. No book should be more carefully read than this, for every page is teeming with valuable suggestions. We can well excuse the labored style of Meynert, for he dealt with the most complicated problems known to medical science. Take him all in all and Meynert was the most interesting and important figure in the neuropathology of the nineteenth century, and through his writings and pupils he has had an influence upon psychiatry and neurology that would be hard to exaggerate.



A Pictorial Atlas of Skin Diseases and Syphilitic Affections, in Photo-Lithochromes from Models in the Museum of the Saint Louis Hospital, Paris. With Explanatory Woodcuts and Text, by ERNEST BESNIER, Physician to the Saint Louis Hospital, etc.; TENNESON, Physician to the Saint Louis Hospital; HALLOPEAU, Member of the Academy of Medicine, etc.; FOURNIER, Professor of the Faculty of Medicine, etc., and DU CASTEL, Physician to the Saint Louis Hospital. With the Co-operation of HENRI FEULARD, Curator of the Museum, and LEON JACQUET, Secretary of the Dermatological Society of France. Edited and annotated by J. J. PRINGLE, M. B., F. R. C. P., Assistant Physician to and Physician to the Department for Diseases of the Skin at the Middlesex Hospital, London. Parts VI., VII. and VIII.; pp. 139 to 194. London: F. J. Rebman. Philadelphia: W. B. Saunders, 1897. St. Louis: The W. T. Keener Co., 404 North Eighth street. Price, \$3.00 per part.

This Atlas continues to maintain its high standard, and, in many instances, even exceeds it. Plate xxi. depicts a very interesting case of the lesions of an habitual cocaine and morphine consumer. The lesions are indurations and ulcers, which closely simulate syphilis in appearance. Some similar cases which we have had occasion to observe simulated syphilis closer. Plate xxii. shows a most pronounced case of ring-worm of the body, and one which can be studied with a great deal of profit. The value of the text may be inferred from the fact that it is from Sabourand's pen. In Plate xxiii. we are given a representation of a case of syphilitic hyperkeratosis in a case which was evidently advanced. The text, by Leon Jacquet, is most excellent. A delineation of psoriasis figurata is given in Plate xxiv. It is a fine example of this particular form of the

disease. Plate xxv. is a particularly fine one, which represents an eruption from bromide of potassium after taking small doses for a short time, and showing a pemphigoid eruption during the period of cicatrizations. The ulcers following the pemphigoid lesions are unusually well shown, and this plate may be justly ranked as among the best which have appeared so far. Plate xxvi. gives a good delineation of hypertrophic papular syphilides, which are seen quite often by those who have an opportunity of seeing any considerable number of cases of syphilis.

A very fine plate is No. xxvii., on which are seen several lesions representing different stages of the rupial syphilide; which are magnificently delineated. An ulcer due to the removal of a rupial crust is not only well shown, but is highly demonstrative of the condition which is actually present. The text which accompanies this plate, and which is by H. Hallopeau, is very interesting. Two cases which are but rarely seen are shown on Plate xxviii. One is that of a gangrenous tubercular syphilide, and the other that of a gangrenous gumma. The latter is particularly good. A most interesting case is that which is shown in Plate xxix. It is a representation of an epithelioma arising from a lupus scar. The possibility of this has been disputed from time to time, but the history and autopsy, as well as the anamnesis, of this case seem to be rather conclusive. Plate xxx. represents a rather marked example of erythema iris, which has been subjected to the misnomer of herpes iris and hydroic erythema. A study of this plate would certainly tend to render clear many cases which have been heretofore misinterpreted.

Lichen planus of the erythematous variety forms the subject of Plate xxxi. The fine scales covering some of the lesions, and the shining, coppery hue of others, are very well shown, and a diagnosis would be easy to any one who has had occasion to observe any. Plate xxxii., which is the last one of Part VIII. of the Atlas, presents two pictures of *Biskra bouton* or aleppo boil, occurring at the end of the nose in its single form, and on the back of the left hand in its multiform phase. The latter resemble greatly syphilitic ulcers which have a crateriform appearance.

The high standard of excellence of the plates, figures and text have been preserved throughout each succeeding part, and we expect to see the same maintained throughout those which will follow. We still desire to reiterate our former advice to both students and physicians to obtain a copy of this most artistic and valuable work, as it is not likely that as good a one will appear for many years to come.

OHMANN-DUMESNIL.

A Pleasant Outing.—For a pleasant as well as a most restful outing, the tired physician cannot do better than take advantage of the delightful trip to St. Paul on one of the Diamond Jo steamers. This company's packets are commodious and well appointed, and their passengers are assured of every courtesy and attention. The scenery of the upper Mississippi is famous for its gentle beauty; numerous picturesque villages nestle among the hills, while many larger cities present much of interest to the tourist.

NEW SUBSCRIBERS.

Few medical journals employ a traveling agent to secure subscriptions, because it is expensive. The TRI-STATE has two solicitors who, regardless of expense, is steadily adding to the subscription list of the journal.

During the hot months of July and August our solicitors were taking a vacation. Most of the subscribers whose names are given below have sent in their orders for the JOURNAL by mail.

Now that the days are cooler, we have placed our solicitors in the field. Miss Katie Hegel will call upon physicians living within 200 miles of St. Louis; and Mr. Fred. W. Colegrove is now at work on the line of the Mobile & Ohio Railway, and, after working this territory carefully, will go into Texas.

Advertisers will please watch this department and the closest scrutiny of our claims is courted. Toward the end of this year we will make a proposition to medical journal advertisers—a proposition so fair and important that it should not be overlooked.

The following subscriptions have been

RECEIVED WITHIN THE LAST 30 DAYS:

- | | |
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 J. W. Weir, Sparta, Ill.
 S. R. Willard, Mound City, Ill.



Dr. M. W. Hoge.—This gentleman has located in St. Louis, and is pleasantly situated at 3502 Franklin avenue. Previous to the advent of the Lon V. Stephens administration, Dr. Hoge was First Assistant Physician at Missouri State Lunatic Asylum, No. 7 (Fulton, Mo.). We welcome the doctor to St. Louis, and wish him success.

Central District (Mo.) Medical Society.—The seventh annual meeting was held in Sedalia, August 5 and 6, 1897. Important papers were read by Doctors A. R. Kieffer, St. Louis; H. E. Pearse, Kansas City; H. W. Latham, Latham; S. H. Redmond, Tipton; Frank De Vilbiss, Spring Garden, and others. Officers were elected as follows: F. De Vilbiss, Spring Garden, President; H. B. Cole, Sedalia, First Vice-President; J. L. Parrish, Pleasant Green, Second Vice-President; J. M. Melvin, Cole Camp, Third Vice-President; G. H. Scott, Sedalia, Treasurer; A. F. Dresel, Sedalia, Secretary.

New Dental College.—The Keokuk (Iowa) Medical College has started a new dental college.

Died.—Dr. Paschal Davis, of Keokuk, Iowa, died July 6th.

The Alumnus.—This is the title of a new and newsy medical monthly which is issued by the Keokuk College of Physicians and Surgeons.

Two Professors Quit.—We regret to learn that there has been trouble in the medical department of the University of Texas (Galveston). Dr. A. G. Clopton, Professor of Physiology and Hygiene, and Dr. H. A. West, Professor of Principles and Practice of Medicine, have resigned.

Died.—Dr. John W. Powell, a prominent physician of Peoria, Ill., died August 5th, after a lengthy illness. He was 59 years of age, and leaves a widow and four children.

A Protest.—Doctors Elmer F. Clapp and C. M. Hobby, of Iowa City, Iowa, are out with an open letter to the Iowa profession regarding the need of a \$150,000 State hospital for the use of the medical department of the University. They desire the enforcement of the following rules:

“*First.*—That no patient should be admitted to the hospital or receive treatment therein who is able to pay, or possesses sufficient means to pay, for his or her treatment at home or in a private institution.

“*Second.*—That no physician or surgeon, a member of such hospital staff, shall receive any compensation for service in such hospital, or receive any pay or gratuity from any patient admitted to such hospital.

“It is our belief that the adoption of such rules would in no way lessen the opportunity for good of a State hospital, and could in no way interfere with the *legitimate* work of the members of the staff.”

That "Smoker."—A great deal of bad taste has been shown by the *Medical Fortnightly* in its criticisms of a "Smoker" held at the recent meeting of the Tri-State Medical Society of Iowa, Illinois and Missouri. All sorts of harsh things have been said by the editor of the aforesaid sheet. By the way, does Norbury remember attending a banquet at Kansas City and one in St. Louis, in honor of the Tri-State? And did he not enjoy the jokes and stories as much as any one?

Resigned.—Dr. Ralph Reder, for three years Assistant Superintendent of the St. Louis City Hospital, has resigned to accept a position with the Burlington Railway, with headquarters at Hannibal, Mo.

Against Funk.—Senator A. B. Funk, of Dickinson county, is a candidate for Governor of Iowa. Senator Funk is the friend and champion of Osteopathy. We have no doubt our Iowa friends will do their duty and Senator A. B. Funk, of Dickinson county, will not be nominated for Governor of Iowa.

Married.—Dr. V. C. Birney, of Greene, Iowa, was married, May 20th, to Miss Rartz, of Charles City.

Removal.—Dr. T. B. Askew, one of our subscribers, has removed from Allison to Waverly, Iowa.

Mississippi Valley Association.—The next meeting of the Mississippi Valley Medical Association will be held in Louisville on October 5th, 6th, 7th, and 8th, 1897. All railroads will offer reduced rates. The President, Dr. Thomas Hunt Stucky, and the Chairman of the Committee of Arrangements, Dr. H. Horace Grant, promise that the meeting will be the most successful in the history of the association, and this promise is warranted by the well-known hospitality of Louisville and Kentucky doctors. Titles of papers should be sent to the Secretary, Dr. H. W. Loeb, 3559 Olive treet, St. Louis.

Chairmen.—L. E. Hornibrook, of Cherokee, Iowa, President-elect of the Iowa State Medical Society, has appointed the following Presidents of Sections: Surgery, J. A. Sherman, of Cherokee; Medicine, H. E. W. Barnes, of Creston; Gynæcology and Obstetrics, C. E. Ruth, of Keokuk; Ophthalmology and Otology, W. B. Small, of Waterloo; State Medicine, A. W. Cantwell, Davenport; Mental and Nervous Diseases, H. A. Gilman, Mt. Pleasant; Materia Medica, B. H. Criley, Dallas Center.

A Valuable Catalogue.—We have received from the McIntosh Battery & Optical Co., of Chicago (521-531 Wabash ave.), a copy of their Eighteenth Edition Catalogue of electro-therapeutical apparatus. In this catalogue the firm have made a radical change in the matter of prices and discounts in this particular, that they have reduced the list prices very greatly and have discontinued the old plan which has been operated so long, of allowing the physician a discount off the list prices. Many physicians never think of the matter of discount, but simply look at the price as given in the catalogue, and most physicians prefer to know "on sight" just what their goods will cost them, without any bother of figuring. We believe this change will result to the advantage of the medical profession, to the

regular trade, and to themselves as manufacturers. In this catalogue the McIntosh Co. have endeavored to cover a full line of such apparatus as the up-to-date physician is on the look-out for.

Removal.—Dr. R. Duncan Hudson has removed from Champ, Mo., to St. Louis, Sixth and Market streets.

Died.—Dr. H. D. Schmidt, a prominent physician of Nashville, Ill., died August 3d, in his 64th year. He was editor of the *Nashville Post*, and had resided in Nashville since 1864.

Opened to Women.—The College of Physicians and Surgeons, of Chicago, which is now the Medical Department of the University of Illinois, has opened its doors to women.

New Book.—The Medical Gazette Publishing Company, of Cleveland, Ohio, announces a small volume soon to be issued with the title "About Children." The author is Dr. Samuel W. Kelley, of the Cleveland College of Physicians and Surgeons. The book will contain six lectures filled with information for nurses, medical practitioners, students and all who have the care of children. Advance orders will be filled in September.

Elected.—At the regular semi-annual meeting of the Indian Territory Medical Association, held at South McAlester, I. T., June 29 and 30, 1897, the following officers were elected for the ensuing year: President, E. R. Allen, M. D., South McAlester, I. T.; First Vice-President, G. W. West, M. D., Eufala, I. T.; Second Vice-President, L. A. Roletin, M. D., Oklahoma City, I. T.; Secretary, LeRoy Long, M. D., Caddo, I. T. The next meeting of the association will be held at Muskogee, I. T., December 7 and 8, 1897.

A Strange Journal.—The *Medical Fortnightly*, which purports to be a St. Louis publication, is edited in Jacksonville, Ill., printed and mailed in St. Joseph, Mo., and is owned by a job printer—not by doctors, as has been supposed. This illegitimate sheet claims an "average guaranteed circulation of 8000 copies." We are in position to prove that, two years ago, it did not have 500 actual *bona fide* subscribers.

Removal.—W. L. Whipple, M. D., D. D. S., has removed from Grand and Finney avenues to rooms 611 and 612 Holland Building, St. Louis.

The B. & O. S. W. Ry.—Physicians of St. Louis and vicinity who expect to attend the meeting of the Mississippi Valley Medical Association, at Louisville, October 5th, 6th, 7th and 8th, will do well to travel via the Baltimore & Ohio South-Western Railway. All information concerning this route will be cheerfully given by Mr. W. P. Townsend, 105 North Broadway, St. Louis. We can cheerfully recommend this line for speed, safety and comfort.

Change of Business.—We have the pleasure to announce that Mr. Lewis S. Matthews has assumed the Medical Book business formerly conducted by The W. T. Keener Co. Mr. Matthews has been associated with the above company in Chicago for a number of years and is thoroughly experienced and well informed on Medical Books. We expect he will soon gain the confidence and patronage of the profession.

FORMULÆ.

For Gonorrhœa.—Dr. J. G. Möhlau, of Buffalo, writes in the *New York Medical Journal*: The best of all remedial injections I have ever used in (gonorrhœal) urethritis, chronic or acute, is the following:

℞
 Antipyrin 10.0
 Tinct. ferri chlor. . 10.0
 Trit. bene et adde.
 Aquæ dest. q. s. ad. 150.0 to 250.0

I use a six-ounce syringe (Utzmann) with a Mercier (coudé) catheter, which I insert as far as the prostatic urethra; inject after having cleaned the urethra with six to twelve ounces of boiled water. I next inject three to four syringefuls, so that about six ounces enter the bladder, in order to prevent cystitis. It all passes out alongside of the catheter.

Airol Paste in the Treatment of Wounds.—Burns recommends a paste of the following composition for covering sutured wounds:

℞
 Airol,
 Mucilage of gum } each 10 parts
 arabic,
 Glycerin,
 White bole 20 parts

M. The paste should be spread on evenly and covered with a thin layer of cotton and a slightly compressive bandage. It dries rapidly, adheres well, works powerfully as an antiseptic, is absolutely unirritating to the skin, and allows the serous secretion of the wound to pass

through it. It surely prevents infection of punctured wounds by germs from the skin.—*New York Med. Jour.*

For Administering Diuretin.—The following formula for the administration of diuretin is recommended:

℞
 Diuretin 4–6 parts
 Aq. menth. pip. . 100 parts
 Aq. destillat. . . 90 parts
 Syr. simp. . . . 10 parts

M. Sig. Two tablespoonfuls every two or three hours.

A Powder for Vaginal Injections.—The following formula (*Semaine médicale; Rrogrès médical*) is attributed to House:

℞
 Powdered alum,
 Powdered boric acid, } each 1 ounce
 Powdered borax,
 Hydrastine sulphate . . 9 grains
 Carbolic acid, } each . 20 drops
 Ess. of cinnamon,

M. For each injection, dissolve a teaspoonful of the powder in a pint of water.—*Med. Record.*

To Prevent Rusting.—Steel instruments may be prevented from rusting by a watery two per cent. solution of either sodium carbonate or bicarbonate, sodium borate or benzoate. Morechal in '93 put needles, knives and a nickel watch in such solution and they were free of rust after two years.

ABSTRACTS.

Infection by Flies.—An outbreak of cholera in the gaol at Burwan is described by Surgeon-Captain W. J. Buchanan, M. B., who attributes it to infection carried by flies. Although no bacteriological investigation was made, and thus no actual proof was obtained that the food had become infected in the way suggested, the circumstances of the case as detailed by him make it extremely probable that the cholera microbes were carried by flies from some infected huts outside the gaol walls to the place where the prisoners who suffered were fed. The prisoners were divided into two gangs, each of which was fed separately and had its food separately cooked. The prisoners of the batch in which the disease occurred were fed in a part of the gaol enclosure near the infected huts outside, while those in the other batch were fed at the opposite extremity of the enclosure, and it is to be noted that the wind was blowing strongly from the infected huts towards the feeding place of the gang which was attacked. It is, therefore, considered probable that swarms of flies were blown from these huts, and on reaching the trees and the high gaol wall obtained shelter from the storm and settled on the food exposed in plates before the gang of prisoners who were feeding at this corner. It is clear that we are as yet only at the fringe of this question of conveyance of infection by winged insects. The demonstration which was given last year at the Royal Society of the power possessed by flies not only of carrying bacteria about with them for considerable distances, but of retaining the infection for considerable periods of time, makes it extremely probable that these animals are the active agents in the production of many as yet inexplicable outbreaks of disease, and strongly suggests the possibility of their being the mechanism by which the aerial convection of small-pox is brought about.—*Indian Med. Gazette.*

Bacteriology of the Genital Tract in Women.—Menge and Kroenig have recently published a volume on this subject. A review of this volume demonstrates anew the fact that the normal puerperal uterus is free from bacteria. In 19 per cent of puerperal women who had fever, streptococci were present. So far as the streptococcus and staphylococcus of pus and the bacterium coli commune are concerned, they do not exist normally in the genital tract. The exact method of infection in many cases is hard to determine. It is possible that bacteria endogenous to the skin may cause puerperal infection, if conveyed to the genital tract.—*American Journal of the Medical Sciences.*

Appendicitis.—Dr. Hunter McGuire, of Richmond, Va., reports in the *Southern Medical Record* a series of twenty-six cases, an analysis of which shows that nineteen were of the chronic form, seven of the acute; thirteen occurred in males and thirteen in females; twenty-five recovered and one died. The success obtained he considers largely due to the fact that whenever practical he operates in the quiescent stage, when danger of sepsis has

passed and inflammatory symptoms have disappeared. In more than one instance he has waited, with some risk to the patient, until the acute symptoms have passed off and sufficient time has elapsed for all inflammation to disappear. The treatment during this period consists in keeping bowels freely open, diet, restriction of exercise by confinement to room or bed, and one-thirtieth grain bichloride of mercury three or four times a day.

He is opposed to an operation in all cases as soon as a positive diagnosis is made, as fully one-half of all cases recover from the first attack, spontaneous resolution taking place when peritonitis, exudation and sometimes suppuration have been present. When the attack is severe and sudden, the pain intense, pulse rapid, temperature high, respiration short and thoracic, abdomen hard and distended, face pinched and anxious, the one hope for life is an operation, the sooner the better. In the fulminating cases we are not warranted in waiting an hour for a trial of medicinal measures. The temperature is no guide, as the effect of the disease on the sympathetic nervous system is so profound as to keep it below normal. The pulse is the important systemic note, it being small, thready and frequent—the “abdominal pulse.” A saline purgative in an ordinary case of appendicitis, not a fulminating one, is valuable for good. By it the bowel and peritoneum are “bled” and the congestion lessened. If the disease continues after purgation, the abdomen is left in better condition for a future surgical operation. If after free purgation the pain continues, the pulse is rapid and the belly tender, an operation should be done at once.

The writer's experience has not borne out the views of many, that males have appendicitis more often than females; in a series of one hundred and fifty-five the cases are nearly equal in the two sexes. An operation should not be postponed on account of pregnancy should appendicitis develop at this period. As to the technique of operation when an abscess is present, he advises that the abdomen be opened by a long incision, the appendix cut off and the abdomen flushed out with gallons of sterile water. The wound should not be sutured. Deep-seated localized abscess should be rendered accessible by a free abdominal incision, pus sponged out and the appendix carefully searched for and removed. In cases where the abscess has approached the anterior abdominal wall and become adherent to the peritoneum, an opening is made for drainage and no effort made to extract the appendix if not loose, or to remove the wall. In cases of chronic or relapsing appendicitis, operation is not advised until the patient has had two attacks.—*Mathew's Quarterly Journal of Rectal and Gastro-Intestinal Diseases.*

Acetone in the Urine of Pregnant Patients as an Indication of Foetal Death.—Knapp reports, from the German obstetrical clinic of Prague, ten cases of foetal death at various periods of gestation in which, upon the day of labor, acetone was found in the urine; this substance was also present during the three days following labor. Some of these patients were syphilitic, but the influence of syphilis upon the presence of acetone is not determined. Half of the cases reported had suffered from syphilis, or were syphilitic at the time of pregnancy.

To ascertain the presence of acetone Jaksch's method was followed; this consists essentially in adding to the urine nitro-prusside of sodium, and then either caustic soda or potassa to alkaline reaction. Acetic acid

is then dropped into the fluid until the characteristic purple or violet color develops.

The Uses of Suppositories in Children.—Owing to the sensitiveness of the digestive tract in children, and the ease with which its condition may be disturbed by medication, a writer in *La Médecine Moderne*, makes a plea for the more extensive use of medicated rectal suppositories. The medicine in these suppositories must be in a state capable of rapid and complete absorption, and the vehicle also must be considered. Cocoa butter does not remain sufficiently long in situ. The ideal vehicle is found in a mixture of gelatin and glycerin, recommended by Chaumel. To take a practical illustration: In the case of a nervous, excited child, a suppository containing cocain or antipyrin is introduced, and in a short time its calming anti-spasmodic effect is produced—both systemically and locally at a portion of the intestinal tract where irritation often exists—and without disturbing in the least degree the stomach and intestines.—*Pacific Medical Journal*.

Formaldehyde.—F. J. C. Bird, in the *Pharmaceutical Journal*, says that one part of formaldehyde in this table represents two and one-half parts of the full strength, or forty per cent. solution of commerce. A solution of formaldehyde:

1:125,000 kills anthrax bacilli.

1:50,000 prevents the development of typhus bacilli, etc.

1:32,000 preserves milk for several days.

1:25,000 forms a useful injection in leucorrhœa, etc.

1:20,000 preserves wines, weak alcoholic liquids, and beer, also milk for several weeks.

1:4,000 is recommended for moistening paper used to cover jam, etc.

1:3,200 for rinsing dairy vessels, etc.

1:2,500 destroys the most resistant micro-organism in one hour.

1:2,000 for rinsing casks and vessels intended for liquids liable to fermentation.

1:500 for the irrigation of catheters, etc., and as a mouth wash.

1:250 to 200 is a general disinfectant solution for washing hands, instruments, etc., in surgery, spraying in sick-rooms, and as a deodorant.

1:160 to 100 hardens microscopic tissues, which should be immersed for a considerable time to give the best results.

1:100 in lupus, psoriasis, and skin diseases.

1:50 to 25 sterilizes surgical catgut, silk, etc., by steeping.

1:25 for quickly hardening and preserving for microscopical sections; longer immersion in a weaker solution gives better results.

1:10 for hardening very firm tissues in pathological and histological work.

1:5 for hardening firm tissues in such work.

1:2- $\frac{1}{2}$ for hardening soft tissues for the same purpose.

The fact that water absorbs it readily to the extent of a forty per cent. solution renders it easy of application as a disinfectant, and it is in this aqueous solution that it is found in the market, and is thus miscible with water to form any degree of strength desirable.—*Pittsburg Medical Review*.

The Prevention of Venereal Disease.—In the whole range of preventive medicine there is no single class of disease that has hitherto appeared more hopeless as to its outlook than that which is commonly described as “venereal.” The difficulties with which the subject has been surrounded have issued, for the most part, from a sentimental source. To put the matter briefly, a few well-meaning but misguided persons have been allowed to sway the legislature by opposing a blank negation to all efforts to do away with a foul ulcer that has long been eating into the heart of the community. In defiance of the dictates of modern prevention, a specific and peculiarly preventible disease has been allowed to run riot, simply because certain arm-chair sentimentalists have chosen to place the dogmas of their mawkish morality above the wholesome maxims of modern social science. The ancient attitude of these abstract philosophers is to turn aside like the Pharisee of the parable, and then to imagine they have done their duty by the poor wretch stricken down with a loathsome disease at the side of the highway. But the day of such sleek arrogance, we are glad to think, is gone from our midst like many another product of a false puritanism. Nowadays, a logical and pitiless analysis of all the complex conditions of human life is to be witnessed everywhere in the striking departures of advanced thought. Plain speaking is the rule on all matters directly or indirectly involving sex problems, and who shall say that the tendency will not ultimately make for the elevation of mankind? At any rate, it may be fairly asserted that many centuries of abstract optimism have failed to abate by one jot or tittle the scourges of syphilis and gonorrhœa. So that one need not wonder at the spectacle of dissatisfied society turning to other quarters in hope of obtaining the long-craved-for relief. The question that has been so disastrously shelved by the moralists must now be approached by other and more reasonable methods. Prostitution is an admitted evil, but it is none the less the outcome of one of the strongest natural instincts common to all animated life. It is a practice surrounded with peculiar dangers to the health of the community, but which can be curtailed by a supervision like that enforced in the cases of other infectious maladies. Let prostitution, then, be brought within the bounds of administrative official control, and at the same time let all who are suffering from venereal diseases be placed under the purview of the Notification Acts. So far as the military service of the British Empire in India is concerned, the matter may, perhaps, advantageously be put in the following way. It is clear that the moralists who preach at home avail themselves of the principle of the division of the labors of the community by hiring a body of men to protect them and fight their battles. The soldiers thus engaged are naturally chosen from young and able-bodied males, who are well fed and housed, and to whom marriage is forbidden.

What wonder, then, if healthy and high-spirited young men in such an environment should recklessly incur the risks attached to illicit sexual intercourse? In India, especially, the stimulus of a hot climate is an additional incentive to indulgence. These are the plain facts of the case, and as such they will have to be faced. That the present system cannot be allowed to endure is evident from the terrible disclosures of the report of the departmental committee appointed to inquire into the subject. One of the most hopeful signs of the break-up of the reign of the sentimentalists

is the way in which this matter is being almost universally discussed in the public press. An open treatment of such a question would have been impossible ten years since. But the restless spirit of the age speeds onward unceasingly from one intellectual revolution to another. In the present instance we would fain hope that it has taken the hard practical problem of the control of venereal disease forever from the hands of the "shrieking sisterhood" and the peripatetic orator, who have too long been permitted to strut and bluster unchallenged upon public platforms.—*Medical Press and Circular*.

The Osteopaths' Bill.—In the name of every legal practitioner in Illinois we tender Governor Tanner our thanks for vetoing the osteopaths' bill. This extraordinary instrument provided that (1) the practice of osteopathy was not the practice of medicine, and hence the graduates of the "bone-setter's" institution were relieved from the supervision of our State Board of Health; (2) further, that the aforesaid graduates were authorized to practice medicine according to the Kirksville system. No comment is needed. It has been said that the bill was backed by certain financial institutions whose funds were loaned upon stock of the Kirksville college, but we do not vouch for the truth of this statement. The fate of the bank for whose wrecking by this method a certain advertising hernia specialist is now in jail, should warn banks against lending their funds to uphold quackery.—*Alkaloidal Clinic*.

The Need for Rest.—The conscientious doctor works at a tension which, though unappreciated, will, unless occasionally relaxed, lessen his usefulness and shorten his life. Hour after hour and day after day he must listen with unflagging interest to not only the physical, but the family and financial troubles of his patient, mindful that what to him is but an incident in a busy day's work may often be an epoch in the other's life, and that his opinion will be quoted and his advice religiously followed; hence, the need, at intervals, of rest, of change, and of enjoyment. *Bi-Monthly Bulletin*.

The Therapeutic Estimate determined upon Cord. Ol. Morrhuæ Comp. (Hagee) is as follows:

- I. A careful analysis shows the presence therein of those definite alkaloids and active medicinal principles obtainable from fresh cod-liver oil (and to which such oil owes its medicinal qualities), in combination with the hypophosphites of lime and soda. Therefore—
- II. The cordial possesses the therapeutical characteristics of these components, with such physiological actions as are agreeable thereto.
- III. By the same analysis it is shown that in the process of manufacture all and every impure and deleterious element has been removed. Therefore—
- IV. The cordial produces none but the most positive results, and can be administered to any patient, and indefinitely, without creating any repugnance to its use.
- V. It is indicated in all forms of wasting diseases and asthenic conditions.

- VI. It stimulates and supports assimilative nutrition.
- VII. It exerts the influence of an antiseptic and germicide on all micro-organisms.
- VIII. It has an effect at once marked, immediate, progressive and continuous.
- IX. It obviates all degenerative changes.
- X. An agreeable preparation, readily taken, and fully serviceable, it is to be appreciated as a very important addition to the new materia medica.

WILLARD H. MORSE, M. D., F. S. S.,
Matatological Chemist.

Westfield, N. J.

CAMPHO-PHENIQUE POWDER IN THE TREATMENT OF AN ULCER OF THE ANUS.

By WILL S. O'NEAL, M. D., Lancaster, Ky.

THE case was one of a little boy, about two years old, whom I was called to attend. The child on examination was found to be suffering with a deep ulcerated fissure situated at the side of the anal orifice—an ugly-looking lesion, wide and deep enough to contain a partridge egg, and suppurating freely. Having a sample box of campho-phenique powder with me, I determined to try its virtues on the ulcer. I directed the mother to cleanse the cavity thoroughly by washing with carbolized water, and then to fill it with a solution of the powder in oil, 1:8, or one dram to the ounce. This treatment was to be repeated twice daily, morning and night.

Knowing but little of the practical use and virtues of campho-phenique, my idea at the time was to produce a complete fistula, and then to treat the same radically, *secundem artem*. The parents of the child lived some distance out of the way, and I did not have occasion to go in that neighborhood for some four weeks. On this occasion I stopped at the residence and asked the condition of the youngster. He was playing some distance from the house, but his mother found him and brought him up for me to inspect. On examining the ulcer, to my very great surprise, and to the intense satisfaction of the parents, I found the injury almost entirely filled up with healthy granulations—in fact, almost well. Giving the mother a fresh supply of the powder, I directed her to persevere in the treatment, and in the course of a couple of weeks, on passing that way, I found the little fellow entirely well, a perfect cure having been made.

I have since this time had extended experience with CAMPHO-PHENIQUE POWDER, and have come to regard it as the best and most certain agent of which I have any knowledge in the treatment of ulcerations of all descriptions, and particularly of the mucous membranes. I have also had splendid results with it in gynecological practice. In endocervical metritis especially, I have had the finest possible success with it. It has, in short, been used by me in a great number of cases to my complete satisfaction and to the great benefit of my patients. I have, therefore, no hesitation in saying that in my opinion it is all that is claimed for it, and I shall continue to use it in all cases in which it is indicated with entire confidence as to ultimate results.

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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ORIGINAL ARTICLES.

PROSTATIC HYPERTROPHY, WITH REPORT OF THREE CASES.*

By WILLIAM CLAY CARDWELL, M. D., of Carrollton, Ark.



DOCTOR WYETH says that "chronic progressive hypertrophy of the prostate occurs in about one-third of all males who live through the period from fifty to seventy-five years of age. The increase in volume is not a true hyperplasia, for the glandular functions, as well as the muscular power of the organ, decreases with the hypertrophy. In some portions of the mass the muscular tissue is increased, but the bulk of the enlargement is due to the presence of *newly-formed connective tissue.*"

The induration is in proportion to the excess of the new tissue over the normal

muscular and glandular elements.

The enlargement may be local or general.

* Read before the Tri-County Medical Society.

In general hypertrophy, while the increase in size is in all directions, it is more marked in the posterior portion, where it encroaches on the neck of the bladder.

“Not infrequently one lateral lobe is greatly enlarged, or the hypertrophy may be central, resulting in the development of a middle or third lobe, which, by progressive enlargement, not only changes the axis of the normal urethra, but occludes in a variable degree the outlet of the bladder.”

Probably venereal excess is the most generally accepted cause of prostatic hypertrophy.

Symptoms.—The first symptom which attracts the attention of the patient is the obstructed flow of urine. As the obstruction becomes greater, retention of more or less urine occurs, which in time sets up a chronic cystitis, and then urination is more frequent and becomes a painful act. The old man, with commencing hypertrophy, finds that the urine flows in a smaller stream and with less force than usual, and more or less urine drops at his feet. He will have to get up during the night to void his urine, and the number of times this has to be repeated during the night depends upon the amount of cystitis present.

There is thickening of the bladder wall, occasional sacculation, formation of calculi and dilatation of the ureters.

We are told that the anterior surface of the fecal matter passed while at stool is flat.

In many of the cases, these symptoms of obstruction gradually grow worse until complete retention occurs.

The diagnosis of prostatic hypertrophy is not at all difficult. By digital exploration of the rectum we feel the enlarged, round, indurated mass encroaching on the lumen of the bowel from the front. We can also determine whether it be a general or a lateral enlargement by rectal examination. By passing a sound or bougie we can *eliminate* any anterior stricture of the urethra.

Now, given a case of prostatic hypertrophy, how shall we treat it? I wish to devote the most of my time to the treatment, for it is one of the most troublesome diseases with which we came in contact. Wyeth, in his textbook on surgery, published in 1892, says that “the treatment is chiefly palliative,” but in view of the recent advances in surgery, especially in the surgical treatment of this disease, we cannot say that the treatment is chiefly palliative. When first recognized, every source of irritation should be removed. The diet should consist of plain, unstimulating food; no coffee, tea, meats or pastries should be taken as food. Keep the bowels open by daily cathartics, if necessary. Dilute the urine by giving diuretics and drinking large quantities of water; and, above all things, keep the urine bland. From the retention, the urine is almost always alkaline, due to ammoniacal decomposition, and if we give alkaline diuretics, such as the potassium salts, we only increase the alkalinity. To avoid this mistake we have only to use litmus paper to ascertain the reaction. If it is strongly alkaline, give small doses of benzoic acid, which will soon render the urine bland or slightly acid if pushed. All venereal excitement must be prohibited.

By judicious diet and treatment the disease may be arrested, or at least retarded.

As the obstruction progresses, operative interference often becomes necessary. If the gland be symmetrically enlarged, the prostatic urethra may be dilated by the olive-pointed French bougie, or by conical steel sounds. When the enlargement is chiefly posterior, dilatation is not indicated.

When a middle or third lobe of the prostate is enlarged there is a *cul-de-sac* behind the prostate, and it is evident that the bladder cannot be entirely emptied in the erect position, and to prevent cystitis it is very essential to completely empty the bladder at each micturition, and this may be best accomplished in the knee-chest position.

In prostatic hypertrophy, an effort may be made to destroy the hypertrophy by Mercier's instrument, the kiatome. This is a cutting instrument which is used per urethram and acts, after the manner of the lithotrite, by grasping the ball-like hypertrophy of the middle lobe of the prostate. This is a blind operation and is useless, except in those cases of marked middle lobe hypertrophy. To-day it is little used. Suprapubic cystotomy offers the best *route* to this form of obstruction, for it gives the operator an opportunity to see what he is doing. I would do the latter operation in preference to Mercier's operation, but suprapubic cystotomy is followed by mental disturbances and even acute mania in no small per cent. of cases, and the amount of good that can be accomplished is always questionable.

Reports of good results from the administration of extract of sheep's testicles have been made by Brown-Sequard, Cameron, and others.

When the obstruction becomes so great that the bladder cannot be emptied by natural forces, resort may be had to the catheter.

I wish now to turn my attention to two new surgical procedures for the relief of prostatic hypertrophy.

In 1893 Dr. White, of Philadelphia, proposed castration or orchidectomy for this class of cases, and claimed that by removing both testicles atrophy of the enlarged prostate would follow. Different theories as to the cause of the atrophy have been advanced. The most generally accepted theory is that the temporary amelioration of the symptoms is due to a reflex reduction of hyperæmia, and that subsequent shrinkage is due to the medium of the nervous system. In White's report of 111 cases treated by this method, no less than 80 per cent. of recoveries followed. In Ferich's series of 52 cases operated upon, 40 were successful, eight patients died, and in six there was no apparent diminution in the size of the prostate.

The mortality following this operation is small and can be reduced by the selection of proper cases. Any grave constitutional or local disorder contra-indicates operation. One fatal case reported was due to Bright's disease, and another to tuberculosis.

The arguments against the operation are not very well founded. The sentimental objection of parting with the testicles should be small after a man has reached the age of sixty, and the mental derangements which follow a few operations are due, mainly, to uræmic poisoning.

Certainly the results in the reported cases are very flattering. We cannot, however, advise all cases to submit to orchidectomy, since many live a comparatively comfortable catheter life for years.

When an operation is required to relieve a certain case, then castra-

tion must compete with prostatectomy, perineal drainage, Mercier's operation, vasectomy or suprapubic cystotomy, all of which, save vasectomy, are graver operations than castration.

If a patient can lead a comfortable catheter life, let him alone.

The tendency in all cases of prostatic hypertrophy is to grow worse, and the termination has hitherto been, in the majority of cases, death.

The patient who leads the life of catheterization is in constant danger of cystitis, urethritis, retention and uræmia. When one of these symptoms begins to develop, we must do something or soon death will claim our patient. The mortality is less in castration than in any of the operations with which it competes, except vasectomy, and a greater per cent. of recoveries follow it than any other operation for prostatic hypertrophy. Then, why not advise and do it when there is no contra-indication?

Now, let us consider the second of the new operations—vasectomy, or resection of a portion of the vasa deferentia. In 1895 Guyon, of Paris, read a paper before the French Surgical Congress on hypertrophy of the prostate and resection of a portion of the vas deferens.

Reginald Harrison was the first to propose this operation for prostatic hypertrophy. He claims that the connection between the prostate gland and the testicle is only functional, for the circulation and enervation of both of these glands are independent and different in their origin, and that it is consequently natural to suppose that the physiological isolation of these organs by the suppression of the vas deferens would be sufficient to obtain effects analogous to those realized from ablation of the testicles.

Removal or atrophy of the testicle in man is followed by atrophy of the prostate; then in cases in which the vas is destroyed by injury, atrophy of the testicle follows; therefore, divide the vas deferens rather than remove the testicles, if the same results are obtained, for the operation is less dangerous.

In doing vasectomy we must be careful not to include in the ligature the nerves and blood vessels of the cord, or gangrene of the testicle may follow. This operation can be performed without a general anæsthetic. Cocaine or eucaine anæsthesia is sufficient, and the operation will be painless.

Put two ligatures around the vas, about one-half inch apart, and resect that portion of the vas which is between the ligatures. If the prostatic hypertrophy is unilateral, the corresponding vas may be divided; but if the enlargement is symmetrical, double vasectomy should be performed. In the double operation it is preferable to wait a month or so after the first vasectomy before operating on the opposite side. Ferich has studied the record of thirty-seven cases of resection of the vas, and in twenty-six a good result was noted.

Reginald Harrison has operated twenty-two times. He divides his cases in two classes: One group of twelve cases, in which he did only a single operation; a second group, in which he did double vasectomy. Of the first group seven received permanent relief, and he lost sight of the remaining five. Of the second group five received permanent benefit, and five were too recent to judge, or were not benefited.

In these two series of cases, numbering fifty-nine, thirty-eight were permanently benefited; or 64½ per cent.

This operation does not compare favorably with orchidectomy, following which there is 80 per cent. of recoveries; but the latter operation is more dangerous: first, because there is a greater mutilation of tissues; secondly, it requires a general anæsthetic; hence you see that vasectomy may be performed in cases in which a general anæsthetic is contra-indicated; and the sentimental objection is not so great in vasectomy as in castration. If I had good reasons to believe that a patient would live some time, I would not hesitate to do vasectomy. While, on the other hand, if the local symptoms were severe, and there was no contra-indication, I would advise castration, for I believe that it is a more radical operation. If injury to the vas causes atrophy of the testicle, and atrophy of the prostate follows atrophy of the testicle, I see no reason why it should not stand as one of the very best operative procedures for prostatic hypertrophy.

I will now report three cases, not that there is anything unusual, but that I may bring out some symptoms and their treatment more forcibly:

CASE I.—L. T. W.; male; age 78; farmer; American; born in North Carolina, and a typical antique "tar-heel"; married; no history of any specific venereal disease. Always enjoyed good health until twenty years since, when he developed this urinary trouble. Came under observation February 14, 1896, and his general condition was poor. Pulse, 100; temperature, normal; respiration, laborious; *anorexia*. He had a severe dysentery, which had greatly prostrated him; also hemorrhoids. He had a valvular heart disease, from which there was œdema of the face, arms and legs, ascites and marked congestion of the lungs.

Urination was frequent (about every half hour) and very painful; urine came away in a very small stream; urine was strongly alkaline. The prostate was enormously enlarged, as felt through the rectum. I tried to pass a small steel sound after having cocainized the urethra, but the pain was so great when it reached the membranous portion he would not permit me to pass it further; neither would he allow me pass a soft rubber catheter. He had a severe urethritis and cystitis. I say that he had a cystitis, and he did, if the symptoms as given in the text-books are correct. Naturally we ask ourselves what caused this cystitis. Senn, in his work on surgical pathology, and Park, in his text-book on surgery by American authors, say that there is no inflammation but that is caused by specific organisms. In this case there was no chance for specific organisms to be introduced into the bladder from without. Then, they must have gained entrance through the kidneys.

I am inclined to believe the teachings of the pathologists of to-day, that all inflammations are caused by germs. Pyogenic bacteria are not infrequently eliminated through the urine. Park tells us that the specific organisms of pneumonia, typhoid and erysipelas, are found in the urine during acute infection; also, the bacilli coli communis are found in the urine. Then, if these specific infectious organisms are eliminated by the kidneys and found in the urine, why do not all of us have cystitis? Because the normal urine is antiseptic, and as long as the bladder mucous membrane is healthy, and the urine has its antiseptic property, the bladder is able to resist the invasion of these germs. Just as the healthy lungs are able to resist the tubercle bacilli and the diplococcus of *Frankel*. When there is obstruction to the outflow of urine from the bladder, reten-

tion occurs; the bladder mucous membrane becomes congested and the urine alkaline. Now we have a favorable soil for the development of germs. Germs thrive better in an alkaline medium as a rule. This is my explanation of the cause of cystitis in this case.

Pardon me, gentlemen, for this digression, and I will go on with the report of my cases. In this case I gave a heart tonic, treated the dysentery, regulated his diet, and gave benzoic acid and fl. ex. buchu for the bladder symptoms.

February 17th. All symptoms much improved, especially the dysentery and the heart symptoms.

February 18th. The heart was very irregular and feeble in action; breathing difficult; œdema greater. By vigorous stimulation the heart soon regained its usual power and regularity.

Still, he would not permit me to pass a catheter.

February 29th. He was much better in every respect than he had been for months.

March 1st. He died suddenly at 3 A. M., without the least warning. Surely, this was a case of "heart failure" that we hear so much about.

CASE II.—May 11, 1896, I was called to see Col. T. D.; age 79; married. Always enjoyed good health, except he had double indirect inguinal hernia and hemorrhoids until about two years since, when this urinary trouble began. Family history splendid.

The first bladder symptoms were frequent and slightly obstructed, painful micturition, which he attributed to an ill-fitting truss which he wore; but, of course, it was due to the beginning hypertrophy. At this time he had loss of appetite, constipation, and had to urinate every half hour, and the act was extremely painful. The right lobe of the prostate gland was very much enlarged, as felt through the rectum. I gave benzoic acid and buchu for the bladder and a saline purgative.

At 2 P. M. next day, May 12th, Dr. H. L. Rauth saw him with me. He had complete retention now and had not passed any urine for twelve hours. He was suffering very much, and we gave him one-fourth grain morphine and tried to introduce a soft rubber catheter, but failed; then we tried an ordinary metal male catheter, which failed to enter the bladder, and after several unsuccessful efforts with it we concluded to puncture the bladder above the pubes. Before doing this, however, we decided to give him a hot sitz bath and again try the metal catheter; we did this and it proved successful. The silver catheter used was the ordinary male catheter, and I speak of it here only to condemn it in this class of cases, for this reason: in prostatic hypertrophy the prostatic urethra is elongated and the bladder is raised more into the false pelvis; consequently, the curve in the ordinary catheter is too short, and in introducing it the eye end plows along the anterior surface of the prostatic urethra, producing great pain and injury to the parts. I then obtained a prostatic catheter, and you can understand the advantage in the long curve and the greater length it has from the eye to the curve. In order to introduce the ordinary silver catheter it must be well depressed between the thighs, which, as above stated, throws the eye end against the anterior wall of the prostatic urethra and often prevents its further introduction.

We then gave this patient alkaline diuretics and salol, to render the

urine antiseptic, also quinine and strychnia as a tonic. Quinine is contra-indicated in cystitis, as it increases the vesical tenesmus. In a few days I was able to introduce a soft rubber catheter, No. 8. A., but no larger. It is best to introduce as large a catheter as possible. Sweet oil is the best lubricant. Fill the catheter with sweet oil before attempting to introduce it.

A catheter should be boiled for five minutes at least once a day, and in the meantime keep it in a five per cent. boric acid solution. It was necessary to catheterize our patient from two to three times a day, as he could not void one drop of urine naturally. I irrigated the bladder twice daily with a warm boric acid solution.

His appetite was still poor, but his pulse ranged from 60 to 70 per minute, full and strong. Occasionally his temperature would rise to $99\frac{1}{2}^{\circ}$ or 100° F. May 28th, 10 A. M., just after I had catheterized him and irrigated his bladder, he had a severe rigor, followed by a temperature of 103° F. I could not account for this chill, unless it was due to a beginning urethritis and increasing cystitis and, possibly, the irritation of the catheter. He was very much depressed the balance of the day and was very restless. At 9:30 P. M., same day, I catheterized him and washed out the bladder, and at 10 o'clock he had a mild rigor, which was followed in a half hour by a very severe one. I now suspected the formation of a prostatic abscess. I gave one-fourth grain morphine and three grains acetanilid.

There was no tenderness of the prostate gland, and the chills were hardly malaria, as he had been taking quinine for several days; so I concluded that they were either due to the cystitis and urethritis or to a small prostatic abscess near the urethra. Next day, May 29th, I had Drs. Ray and Rauth to see the case with me. We could not determine the cause of the rigors, and the consultants endorsed my line of treatment. He had no more rigors. Notwithstanding all antiseptic precautions, the frequent use of the catheter excited a severe urethritis—so severe was it that catheterization was unbearable without cocaine anæsthesia, and this made the urethritis worse, for cocaine causes a temporary anæmia, to be followed in a few minutes by marked congestion of the capillaries.

At this crisis I had to do one of three things: First, I could do suprapubic cystotomy, and drain the bladder. Second, I could do perineal or rectal cystotomy. Or, Third, I could introduce a soft rubber catheter and let it remain. I did the latter, with gratifying results, too. The catheter remained in the bladder for ten days; every second day, however, I would remove the catheter and treat the anterior urethritis by using astringent injections, wash out bladder, inject weak solution of nitrate of silver into the bladder, boil the catheter and reintroduce it. In irrigating the bladder I was always careful to prevent air from entering. I had him on the syrup of the iodide of iron, which is said to cause atrophy of the testicles and prostate gland.

At the end of the ten days I removed the catheter and he was able to pass about an ounce of urine at a time. His appetite improved and soon he was up and about the house, and it was necessary to catheterize him only once in the twenty-four hours, to relieve the bladder of the residual urine, which amounted to about two ounces.

I now proposed to do one of the two new operations for prostatic hypertrophy. After explaining fully both operations, the mortality, and the

probable results, he decided to have vasectomy performed. Accordingly, June 12th I shaved the pubes and scrotum, and dressed the scrotum, penis and surrounding skin with a moist sublimate dressing, preparatory to operating on June 14th under cocaine anæsthesia. The nurse, through mistake, gave him a five-grain powder of cocaine. He noticed that there was a mistake, and asked me if it was not cocaine. I told him that it was. He became very much alarmed, in spite of my telling him that it would not hurt him; but, as a matter of fact, I did not know what the effect might be.

I had no stomach tube or pump with me, and thought that it would be useless to give an emetic, as that much cocaine would produce anæsthesia of the gastric mucosa; consequently, I decided to watch him and meet any symptoms which might arise. His pulse soon ran up from 60 to 100 beats per minute, but I felt sure that his fear of grave results caused this accelerated heart action. I watched him for five hours and no symptoms of cocaine poison developed.

June 14th, the day set for operation, patient was so exhausted from the scare of the previous day that he would not permit me to operate.

He improved then in his general condition for several days, but kept delaying the operation.

I did not see him for several days. Was called to see him July 27th, and found him with a temperature of 103° F., pulse 100, no appetite, coated tongue, constipated. Bladder symptoms about the same; urine loaded with pus and mucus. I gave him calomel, followed by quinine and strychnia for general condition, and salol as bladder antiseptic.

The temperature declined, but his appetite did not improve and he gradually lost strength.

In spite of vigorous tonic treatment and irrigation of bladder, he grew worse, refused nourishment either by mouth or rectum, also all medicine, and died 8 p. m. August 16th, from exhaustion. The points of interest in this case are: First, the good results from the use of the prostatic catheter. Second, the chills of unknown origin. Third, the good results obtained from ten days' continuous drainage of bladder by the catheter. Fourth, the large dose of cocaine without untoward symptoms. Fifth, apparent atrophy of the testicles and prostate gland from the syrup of the iodide of iron. The syrup's action on the stomach, however, was very severe and could be given only a short time. I believe that this syrup actually caused atrophy of the testicles and prostate.

CASE III.—Jacob M., age 69; farmer; married. General health good. Has been afflicted with hemorrhoids for years. His urinary trouble began almost two years ago, when he noticed that urination was slightly painful and obstructed, and that he would have to void his urine during the night. He came under observation August 20, 1896. At this time he was suffering greatly from retention of urine; he had not passed more than two ounces in thirty-six hours. The bladder was greatly distended and reached the umbilicus. With little difficulty I passed a No. 10 soft rubber catheter into the bladder and withdrew forty-one ounces of urine, which was strongly ammoniacal.

His general condition was found to be good. Temperature 99°, pulse 90. After cocainizing the anterior urethra I passed Nos. 16, 20 and 21 A steel sounds into bladder.

I gave him benzoic acid and salol for the bladder, and syr. iod. iron for his general condition. He improved in his general condition, but was unable to pass any urine, and the soft rubber catheter had to be introduced from two to five times during the twenty-four hours.

He was in this condition when he came to me for treatment, September 8th. I then began to dilate the prostatic urethra with conical steel sounds and went up the scale until I could pass a No. 21 A. scale without great pain. I decided on this plan of treatment, as he had a symmetrically enlarged prostate. I also irrigated the bladder with warm boric acid solution, and gave him strychnia and salol. September 9th I again passed steel sounds and irrigated the bladder twice.

September 10th he was able to void about two ounces of urine every four or five hours. I did not attempt to pass a larger sound than No. 21, as the pain was considerable and resistance marked. By straining he could force out a rather large stream of urine, which led one to believe that his retention was not due so much to obstruction as it was to loss of tonicity of the bladder wall, from overdilatation. I kept up the strychnia and salol, and gave benzoic acid and citrate of potassium alternately. I prohibited meats, coffee and pastries; gave large quantities of milk.

September 22d he returned. He had to catheterize himself only once a day to relieve the bladder of the residual urine. His appetite was good, and he was full of hope and cheer.

The stream of urine was almost natural, and he had very little pain in voiding it. I again dilated the neck of bladder by the steel sounds. I kept him on strychnia, which seemed to be restoring the tonicity of the bladder-walls, also kept urine bland. He was constipated, so I advised rectal enemas of cold water once a day. Before leaving, on the 27th of September, he told me that his bladder was in better condition than it had been since it became diseased. In a letter of March 20, 1897, he said that he was doing well.

In the report of these three cases you see a great difference in the results of the palliative treatment. Castration or vasectomy was indicated in cases I. and II., but had I done an operation in case I. the patient would likely have died from the heart disease, and, of course, it would have marred the statistics of the operation.

I believe that if an operation such as castration had been performed in case II. at the time he took the cocaine, success would have followed. Now, in case III. under treatment which is altogether palliative, I do not think that an operation is demanded, for he is in good condition and improving in general health. If, however, he grows worse, I will insist on doing orchidectomy, as he has hydrocele of the left tunica vaginalis, and there is no contra-indication to the operation.

Since writing this paper I have received the latest literature on castration, vasectomy, complete ligation of the cord, and ligation of the vessels of the cord, for prostatic hypertrophy, from Dr. White, of Philadelphia, and it includes the full report of the 111 cases spoken of in this paper, with twenty-four new cases, making in all 135 cases reported by White, with a mortality of 17.9 per cent. But, throwing out the obviously inappropriate cases, fifteen in number, it leaves only eight deaths in 120 cases, or 6.2 per cent.

In 71.3 per cent. of the patients under observation after three months, the patients appeared to have their health permanently re-established.

Ability to urinate occurred in 66 per cent. of cases soon after operation; and ease of catheterization in 75 per cent. of cases. A surprising phenomenon is the disappearance of a previously intractable cystitis in 52 per cent. of the cases, and the return of the power of the bladder in 66 per cent. of cases is as surprising as the disappearance of the cystitis. Even in the desperate cases it is interesting to note that 75 per cent. showed some distinct improvement in symptoms, or some shrinkage of the prostate occurred before they died. Only 10 per cent. of the cases that recovered are apparent failures. No mental or physical changes whatever (except favorable ones) have been noted in a single one of all the successful cases.

As before stated, castration compares favorably with all other operations in mortality. The mortality of suprapubic prostatectomy is 20 per cent.; of perineal prostatectomy is 14.3 per cent.; while the true mortality of castration is not greater than 7 per cent., and the degree of relief experienced, and the percentage of cases that may fairly be called "cures," are both far in advance of the results obtained by other methods.

The results in unilateral castration are not nearly so good as in double castration.

In experimenting on dogs, all the cases in which the vessels of the cord, or the whole cord, was ligated, atrophy followed, but not until after the cord and testicle had sloughed.

In the light of these facts I believe that castration offers greater chances of relief to the patient than any other treatment for prostatic hypertrophy; "that excision of the vas deferens to be a justifiable experiment, especially in all cases which, while otherwise fitted for castration, are either so ill that even that operation becomes dangerous, or so well that they are prevented by sentimental reasons from attempting to arrest in that way an overgrowth of the prostate that unrelieved would surely end their lives, after a more or less prolonged period of great suffering."

Blanke's Kofeko.—We call our readers' attention to the advertisement of "Kofeko," the original malted grain coffee. This product is pure and wholesome, and is a wonderful discovery and benefit to mankind. It is specially prepared to meet the requirements of the sick room and is recommended by eminent physicians who have tested its value as a substitute for coffee. Kofeko is nourishing as well as invigorating, no matter how weak the stomach; it will build up the system and make rich, healthy blood. The Blanke Tea and Coffee Co., of St. Louis, agree to furnish our readers with sufficient quantity for experiment, by mail, free, upon mentioning THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

THE CLIMATE OF SOUTHERN CALIFORNIA FOR INVALIDS.

By J. F. T. JENKINS, C. M., M. D., M. C. P. S., Quebec, of Los Angeles.
Member Los Angeles County Medical Association, Southern California Academy
of Sciences, etc.



THE WRITER, when a resident of Montreal, in an article furnished by him to *L'Union Medicale Du Canada*, entitled *Du Climat de la Californie*, attempted a description of the many varieties of climate in the different parts of the State, but having occasion subsequently to give the matter greater study and more careful investigation in the preparation of a report for *The Canada Medical Record*, he was led to see the greater advantages of this particular section over all other portions of the Pacific slope, especially for all pulmonary invalids.

It will be seen that Southern California deserves its unequaled reputation for health.

Thousands are living here now, as well as in various parts of the Eastern States and Europe, who are indebted to its salubrious atmosphere for extended lives, having secured a complete arrest of disease. A great deal has been well and ably written on the climatology of this country, but it will stand many additions to what has been already written and still leave a heavy balance in its favor available for the descriptive powers of future writers, whether viewed from a medical standpoint or otherwise.

None know better than physicians that *no one spot suits all classes of cases*, or that no given locality is perfect; but within the limits of this *truly wonderful sanitarium* almost all varieties of climate can be obtained—any desired elevation, with a corresponding change in temperature, from the delightful, balmy air amongst the orange groves in the valleys, to the icy breath of the lofty snow-capped peaks of the grand old mountains towering above.

Let us consider what we have in the climate of this portion of the State, which, owing to its reputation as a resort for invalids, has brought more than one-third of its population here. In the first place, we have a dry, bracing, cool climate, abundance of sunshine, together with a highly electric and antiseptic atmosphere, at elevations ranging from a few hundred to thousands of feet. Vast plains and magnificent mountains to supply us with unlimited air, untainted by vegetation or unpolluted by the sewerage of great cities.

As regards humidity, by comparing the actual number of grains of vapor to a cubic foot of air, we find we have as little as can be found in any habitable portion of the globe; yet, withal, in each colony and settlement an abundant supply of the purest and best water, both for domestic use and irrigating purposes.

A glance at Lombard's Medical Geography will show that wherever the shading indicates moisture there is a much greater mortality from consumption among the inhabitants. Volumes have been written proving the relationship of moisture to pulmonary disease wherever the human race is found.

With so little rainfall we have, consequently, a greater number of clear days—we may safely say at least 320 in the year, and in some districts even 340, and the remainder cannot be considered in any sense as unpleasant as is experienced in the Atlantic States the greater part of the time.

It is a matter of regret that hundreds are annually induced to come here whose cases are perfectly hopeless. Those who seek any portion of Southern California for their health should not make the fatal mistake of postponing their coming too long and then expect a miraculous cure. It is the height of folly to make a change under such circumstances. Do not wait too long and then seek California as a forlorn hope. Do not leave the accustomed comforts of home and the consolation of near relationship. No one appreciates the blessings of home until sick, and no invalid fully realizes its inestimable value until left behind.

It is easy to say much about the climate of this charming section of the State, but difficult to describe it in a way to be applied generally and at the same time be clearly understood. Space forbids a separate description of its numerous attractive health resorts. It is possible in some countries to live a short time in one place and then generalize correctly in regard to the whole; but this is too heterogeneous a country for such easy descriptions. Thus, owing to a combination of peculiar circumstances, it is difficult to give an adequate idea of the unequalled healthfulness and unsurpassed beauties of this lovely, sunny southern land. We have the climate of the coast, the climate of the mountains, and all the varying degrees of difference between these points, which must be experienced to be appreciated.

In order to have a correct idea of Southern California it is necessary to study the climatic laws of the State as a whole. Its topography must be outlined to give the observant reader an exact knowledge of the reasons for the many varieties of climate to be found in so small an area. The most important characteristic in its physical geography is the fact that its mountains, the total length of the State, follow the coast line. There are two great ranges: one, the coast range, rising almost directly from the seashore, with here and there an indentation forming a valley fronting on the ocean; the other great mountain chain, the lofty Sierra Nevada, separating the Pacific slope from the great interior country beyond. Between these two great ranges we have one class of climatic features depending upon elevation, distance from the sea, and various local conditions; and outside the coast range, looking out upon the ocean, a widely different climate marked by greater humidity and a more even temperature than the interior dryer valleys. Not only the exterior valleys of the coast range, but also the interior valleys lying between the coast range and the Sierra Nevada, benefit by the sea breeze as it gains an entrance through numerous openings or breaks in the lower mountains of the coast, and in this way the interior system of valleys is saved from what would otherwise be an excessive temperature.

Another important physical feature of the southern portion of the State is the Sierra Madre range of mountains, bounding the southern tier of counties on the north. Nature has thus provided a natural barrier against the cold blasts of the northern regions.

The Sierra Madre arises at a point where the coast range and the Sierra Nevada run together. Out of a confused jumble of mountains in the neighborhood of Tejon and Tehachepi, the Sierra Madre emerges and, following the western boundary of the Mojave Desert, runs east along the northern boundary of Los Angeles and San Bernardino counties, then turning to the south follows the western rim of the Colorado Desert and goes on to form the main ridge of Lower California. Within the limits of this charmed circle may be found all the varieties of climate referred to. From the sea-level to an elevation of from six to eleven thousand feet may be seen beautiful valleys nestling under snow-clad crests and looking out upon the waters of the warm southern ocean.

The soft, warm air of the interior valleys permits the raising of semi-tropic fruits, such as the orange, lemon and lime, not extensively grown to perfection elsewhere on this coast; and the juicy, green leaves of the olive and fig trees show the mildness of a climate where such perfection can be attained.

Along the base of the Sierra Madre, behind Pasadena, Pomona, Ontario, Etiwanda, San Bernardino, Redlands and on to the San Gorgonio Pass, the air becoming warmer and dryer as we go inland until we reach the verge of the great rainless desert, is a breastwork of foot-hills high and dry above the fogs which are occasionally present in the lower lands. Here the ocean breeze loses its moisture, and it is particularly suited to pulmonary invalids. This is also the frostless belt, where citrus fruits are grown to perfection.

Winter fogs and frosts follow certain well-defined lines, many sections escaping entirely. It is only opposite the great breaks in the coast range that the winter moist winds find an entrance. They lose much of their moisture in passing over the intervening foot-hills, and pass on to give a light rainfall upon the valley and mesa lands of the interior. Whatever moisture is left is lost in climbing the tall Sierras, and the mountain peaks complete the work of condensation, wringing out from the clouds their moisture in this cold air, giving a rainfall greater than which fell in the valleys. The drainage of this immense water-shed overlooking the whole tier of valleys gives the main supply of water for irrigation purposes during the drier seasons of the year.

From Point Conception to San Diego, and from the coast to the desert, throughout all the varying climatic conditions found in this territory, there is yet the same soft sky, the invigorating atmosphere and mild, soothing influence which cannot be obtained elsewhere on the continent of America, if in the world.

PARTURITION WITH BREECH PRESENTATION.

By J. B. ASHFORD, M. D., of Sherwood, Texas.



PATIENT was a multipara, aged 30 years, and this was the second child. The case occurred early one Sunday morning. After the usual aseptic precautions with regards to cleansing hands, I examined the patient and found labor progressing slowly; the os uteri being dilated to about the size of one inch in diameter. At this stage I administered one dose quinine sulph., 2 gr. in capsule, as an oxytocic. After waiting something near an hour, and concluding the labor was coming on rather slowly, I made another digital examination, after first having thoroughly oiled the index

finger with *oleum olivæ*, and found the os uteri slightly more dilated. At this stage, in order to assist and accelerate dilation, I gave 20 gr. chloral hydrate. After waiting a short time, and upon further examination, found a breech presentation—first position, child lying in the right oblique diameter of the pelvis. Near the end of the second hour of what appeared to be a very tedious labor, I administered a dose of *nux vomica*, well diluted in water, to support the strength and circulation, also to increase uterine contraction; as progress seemed to be very slow up to this time, the patient losing conservation of abdominal force by the manner in which the respirations were used. At this stage the patient was requested to take the knee and chest position for a few minutes—or as long as comfortable between labor efforts, which quite soon afterwards seemed to assist materially and advance the labor.

At the beginning of the second stage, the pains being very severe, requested my assistant to use chloroform quite freely, at intervals, with good effect, lessening sensibility, quieting the patient and assisting labor generally, without any untoward effects afterward, and as the nates or breech came into the passage or plane of outlet, the feet were reached for and brought down after some traction; the hands and arms were also straightened out from their folded position on the breast, and as soon as possible the cord was loosened on the neck—the semi-rotation of the body as it passed downward assisted in lessening the tension on the cord. In delivering the head, gentle traction was made, the chin being assisted over the perineum, which was guarded by the hand—the labor efforts at this time were not undesirably forcible, but slow and steady, with quite long intermissions of time between them; abdominal pressure just above the pubis by my assistant helped materially in releasing the head. The short period of time elapsing just before the head was born caused the child to become cyanosed—indeed, it was not born with a cry immediately upon its arrival—in fact, the pulsations in the cord at this time were very weak; the child was completely cyanosed, relaxed and without breath. A very quick examination was made, there being no time to loose; it was turned on its face and percussed with the hand on the back, cool water being sprinkled

upon the body and the extremities wrapped in warm cloths to stimulate reaction. Sylvester's method of resuscitation was then used: raising and lowering the arms to inflate the lungs, also blowing air into the open mouth without contact or any tube. After these manipulations for a period of about fifteen or twenty minutes the child began to revive and began breathing and crying. Its color began to return and the pulsations in the cord, which up to this time had been very weak, grew stronger and lasted the usual length of time, after which the cord was tied and severed.

When the child was first delivered, I directed my assistant to give the usual one drachm dose of ergot. Uterine action being somewhat feeble, digital manipulation with slight traction on the cord removed the placenta intact.

The following medicine for after-pains being used, the case made a speedy recovery with no disagreeable complications of any kind—thus ended my first case of breech presentation:

℞ Tinct. celery semina.....	ʒ	vj
Aletris farinosa.....	ʒ	vj
Ergot fl. ext.....	ʒ	j
Aqua dest.....	ʒ	j

M. Sig. One teaspoonful from one to four hours apart, as indicated.

These medicines used in other cases of parturition usually give desired results. Perhaps this report may interest some of the younger of the medical profession who have yet to gain a lifetime of experience.

My best wishes to the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER, and may it long live to execute good work in behalf of professional ethics among physicians and surgeons and to the everlasting disqualification of those so-called doctors who practice (for pay) in a free public hospital and dispensary.

STRICTURE OF THE URETHRA, WITH SLOUGHING OF PERINEAL TISSUES.

By OTTO SUTTER, M. D., of Saint Louis.
Superintendent of the City Hospital.



EDWARD C., aged 30, coachman, has had gonorrhœa several times. About three months ago patient experienced some pain while micturating, also had a gleety discharge, with a diminution in the volume of urine. A week ago he had extreme difficulty in passing urine, owing to the contraction of the urethral canal at the seat of the stricture; this condition continued to become more aggravated until at last no urine passed, and during the thirty-six hours previous to having come under my care, patient claims to have not passed a drop of urine. The picture presented by

patient on his entry in the hospital was as follows:

Profuse cold sweat on face, hands and extremities, pulse very rapid and of poor volume, anxious expression of face, temperature 101° , tongue dry. The distended bladder extended to the umbilicus. The structures composing the abdominal wall in the right and left inguinal and pubic regions, together with the perineum, scrotum and penis, were gangrenous, and extensive sloughing was present, owing to the infiltration of these regions with urine. Phimosis was marked.

After anæsthetizing patient attempts were made to pass a filiform bougie, which could not be done, owing to a tight stricture in the membranous portion of urethra. Numerous false passages were present. An external perineal urethrotomy was performed, according to Cock's method; the redundant and contracted prepuce was excised, and numerous incisions



Dr. Sutter's Case of Sloughing of the Perineal Tissues.

were made over the infiltrated gangrenous area. Through these tissues a great amount of pus and extravasated urine exuded. The stricture was excised. Patient made an uneventful recovery; the perineal wound closed completely. The scrotum and penis were very much contracted, owing to the loss of tissue. A No. 29 sound could be passed with ease by patient when he was discharged from the hospital.

This patient had much marked infiltration of urine and gangrene resulting therefrom.

I have had an opportunity of noticing very marked cases of infiltration resulting in sloughing of tissues, but this case is one of the most severe that I have seen.

KELOID.

By A. H. OHMANN-DUMESNIL, Saint Louis.



VERY dermatologist knows that there are many skin diseases which are but rarely or never observed in Caucasians but which nevertheless, are seen rather frequently in other races. This is said to be dependent upon susceptibility; but this is really begging the question, as it is merely stating the original proposition in another form. It is an attempt at an explanation which, in reality, does not explain. So that we must, perforce, remain contented with the mere statement of a bald fact until some more satisfactory reason can be brought forth. Under these circumstances it may be simply stated as a fact

that among the cutaneous affections which are not commonly observed in white persons, but which seem and actually do occur rather frequently in negroes, may be mentioned keloid. This disease, as most frequently seen, is known as the traumatic variety, and is the result of burns, cuts, lashes, operations, or of any other condition which may cause a traumatism, the keloid occupying the place which would have been occupied by a scar had the trauma healed as it does under ordinary circumstances. The variety which is much rarer is that known as "true" or spontaneous keloid. Plicque makes the statement that true keloid is not only rare, but is a condition whose etiology it is very difficult to establish. He goes on further to state that Wilson, Kaposi, Vidal and Schwimmer altogether have seen but seventy-two cases. Van Harlingen states that he never saw one; and authors in general, who have had a large dermatological experience, do not claim such, so far as having observed cases of spontaneous keloid is concerned. The disease is one of more than ordinary interest, not only from its morphological peculiarities and unusual pathology and pathogeny, but from the further fact that it is one which, up to the present, has seemed to resist all forms of treatment, even such as are thoroughly radical in character. It is seemingly incurable, but this is certainly only due to the fact that the methods hitherto employed are inadequate; and there is no doubt that some method, very probably simple in character, will be discovered which will solve this therapeutic riddle in a satisfactory manner.

Keloid, whose name is derived from the Greek word *Kelis*, signifying a crab (to which it has been said to bear a fancied resemblance), is essentially a neoplasm of the fibrous variety. The disease occurs in the form of tumor-like formations, which are rather flattened, and which may or may not have narrow prolongations. The lesions occur about the chest and back for the most part, although the arms, legs and face may also be involved. The color is usually not so dark as that of the surrounding normal in-

tegument, and here and there upon the surface there may be observed fine blood vessels ramifying in a somewhat stellate form. This latter, however, is not an invariable accompaniment and is frequently absent. To the feel the lesions of keloid have a sort of doughy resistance, which, whilst it is perhaps firmer than that offered by a lipoma, is still not as marked as that offered by a fibroma. It is something very difficult to define, and yet when once it has been felt it is never forgotten and is easily recognized when felt again. The integument covering the keloidal tumor is smooth, sometimes tense and glistening, and not very freely movable or even attached.

Before proceeding further with the general characteristics of keloid it may not be inopportune to give the history of a case of the spontaneous variety which I had occasion to observe some few years ago. S. C., a mulatto, aged 31, and a musician by occupation, gave a good family history. His father died of pneumonia, and his mother, still living, as well as three brothers and one sister, never had any disease. So far as the patient knew, neither syphilis nor tuberculosis ever existed in any of his ascendants. The patient states that he was vaccinated on the right arm at the age of three. When the vaccination healed it was followed by a small tubercle at the site of the scar, and when he was eight years old the tubercle began to enlarge. It continued to do so until it attained the size of a silver dollar in circumference. It was then that new tubercles began to appear upon the right arm only, and they continued to enlarge until they reached their present size. They next appeared upon the chest, as they had done upon the arm, and they followed the same course. Then they made their appearance upon the hips, and then upon the face. Whilst these were enlarging small tubercles would be appearing. The back shows a number of these latter.

When examined the patient was found to be of medium height, well built, inclined to be muscular. He is active and complains of no discomfort, except so far as it is connected with his cutaneous trouble. He presents the following appearance, which is well shown in Figure 1, his back only being shown: Upon the left cheek there is a tumor of the size of a walnut, rather flattened and glistening and traversed by enlarged vessels of an arterial character. Upon the right arm, at the apex of the shoulder, there is a large, flattened tumor, rather depressed at the center. Lower down four other tumors exist on the outer aspect of the arm down to the elbow. These are of various sizes and rather paler than the integument. On the right fore-arm there are two other tumors, also large and projecting, slightly depressed at the center. The apex of the left shoulder is also the seat of a keloidal tumor, three more being upon the left arm, one anteriorly. The left fore-arm is not implicated. Upon the chest a broad, irregular mass occurs over the sternal region, encroaching upon each breast laterally. Upon the right breast there are two small tumors to the left of and about an inch and a half from the nipple, one being slightly larger than the other. Upon the left breast there is a very small tubercle, external to and about an inch and a quarter from the nipple. Below and between the breasts, about two inches either way, is a tumor about an inch long and half an inch in breadth. At the lower border of the left scapula are one or two small nodules, and on the right two well-defined keloidal tumors. Below this numerous small nodules are distributed over the back.

Upon the right buttock there are two large, irregular tumors; and upon the left, one whose shape would seem to suggest that several, which formerly existed, have coalesced. When these tumors are examined it will be found that they are all depressed at their centers, roundish or ovalish in contour, and none pedunculated, a peculiarity to which Plicque called attention long since.



FIG. 1. Keloid

The patient states that whilst the tumors are not particularly uncomfortable, so far as their location and size is concerned, they do occasionally elicit a great deal of pain, this being very much allied to neuralgia in its character. The pain is sharp and shooting, spreading in various directions, and it seems to recognize a keloid as a center of distribution for all of its ramifications over an affected area. There is added to this a certain amount of itching, which may become very marked. In addition to these

subjective symptoms, suppuration is to be found. It is not of a marked character, but rather deep. According to the patient's statement, these tumors have suppurated at times, and the process last for a certain period. It is this destructive action occurring at the center which produces the apparent umbilication which is observed. Handling the keloid does not seem to produce any particular pain under ordinary conditions; but, when the neuralgic pains are present, the mere act of touching it makes the pain more acute.

The history of this case is certainly most instructive, so far as obtaining a good idea of the objective and subjective symptoms of keloid is concerned. There are, however, some points in connection with the disease which are not brought out in the above. The number of keloids observed in different subjects varies greatly. In many there is but one, situated upon the chest, in the form of a flattened mass, extending horizontally and terminating at each extremity in small, narrow prolongations, having much the appearance of thickened scars. This peculiarity of prolongations from the central mass is rather a common one. The chest is certainly the site of predilection of keloid. The back is another locality for this peculiar growth, and here it is most often found in the form of parallel stripes or bars looking very much like scars. Another form is where it occurs as a single roundish or ovalish tumor. A very common locality is the lobes of the ears which have been pierced for earrings. But there is no locality in particular which is immune to keloid. Again, we find cases in which there exists a number of keloids, and they are of different sizes, much depending upon the length of time each one has existed, the older ones naturally being the larger. It may also be generally observed that it is a common occurrence for a more or less flattened or extensive keloid to become depressed to a certain degree at its center, and suppuration may declare itself at one or at several points. This process subsides spontaneously, but is followed by the formation of scars, which are plainly perceptible upon the surface of the growth. The objective symptoms which have been briefly outlined are so easily recognized as to render a diagnosis of a case a comparatively simple matter. This recognition is rendered still easier by a due consideration of the history and of the subjective symptoms which are noted by the patient.

These subjective symptoms, when they manifest themselves, are of quite a marked character. At times there is some itching, which manifests itself, but it is not very marked and really amounts to very little when we take into consideration another symptom, which is a most prominent one and occurs in all forms of the disease and all cases. This symptom consists in a sharp, lancinating, neuralgic and almost unbearable pain, which occasionally becomes excruciating in character, causing the patient to writhe in anguish. It is so acute in its intensity, and persists for such a comparatively long period of time, that the one subject to it becomes positively frantic. It is most irregular in the periods of its manifestations, and it is this very uncertainty as to its appearance that keeps the subject in a constant state of fear and terror at the mere thought of the possibility of its sudden and unexpected appearance. It may be readily surmised what a serious condition such can be in a neurotic, or one whose nervous system has the slightest susceptibility to such psychic disturbances. There is the

further terror added of the possibility of new keloids forming and, in their turn, adding to the agony of the condition already existing.

False keloid is occasionally observed, but it is not to be confounded with the true variety, although it resembles it in no small degree. It is always due to traumatism and greatly simulates scar tissue. It is rarely, if ever, as extensive as true keloid, and it is devoid of the subjective symptoms noted in the latter. In addition to this, it will yield to radical treat-



FIG. 2. False Keloid.

ment, something which the true form has never been known to do. It is for this reason that more than ordinary care should be taken to recognize such cases, on account of the important bearing this has in formulating a prognosis and in procuring successful treatment, where such is indicated. A good example of this peculiar form of pseudo-keloid is shown in Figure 2. The patient, a young, white adult, suffered from tuberculous glands of the neck. He was advised to have them excised, which was accordingly

done by a very competent surgeon. The incisions were quite slow to heal, but finally cicatrization occurred. It was, perhaps, but natural to expect a corded scar, which showed itself. In a comparatively short time, however, small prolongations from the scar made their appearance. This condition is very well shown in the picture. Observing this peculiar condition, the patient applied for relief, fearing that these prolongations would increase in both size and number. The final outcome of the case was all that could be desired. The cicatricial masses were excised, and after two years no recurrence had taken place. An interesting point to note, in connection with the case, is the fact that the patient was white, with no possible admixture of black blood. He never complained of any itching or pain, and requested an operation for purely cosmetic purposes.

Keloid is a growth which has been observed to occur after the age of puberty, in early adult life, as a rule. It does manifest itself during middle age, but those who have escaped it and arrive at old age do not manifest the disease. If they be prone to it, an operation or a traumatism will be followed either by a hypertrophic scar or by a false keloid, which will cause but very little or no trouble beyond that caused by its ugly appearance. The disease itself seems to exercise no predilection for either sex, for it is seen to occur in females as frequently as it does in males. The size of the keloidal tumor seems to bear some relationship to the comparative intensity of the darkness of the skin. It would seem that the more pigment there is in the skin the larger the keloid is, other things being equal. Thus, in the darker negroes keloid seems to be larger than in those who are lighter; and in the white-skinned races it is quite small, as a rule, and never attains a large size. It is such an unusual thing to observe in Caucasians that its presence is accounted almost a rarity.

The essential cause of keloid is unknown. So far as the origin of spontaneous keloid is concerned, nothing at all is known. The most common cause of the more frequently seen form, so far as can be determined from the histories furnished, is traumatism. Such injuries as are caused by burns, cuts, strokes of the lash, blows inflicted with whips, iron bars, pieces of wood, and similar exciting causes, are followed by keloid in those individuals as are susceptible to the disease. The keloid occurs along the whole track of the traumatism, no matter in what portion of the body it may occur, and this new growth presents all the peculiarities and symptoms inherent to the disease. There is no doubt, whatever, that a certain susceptibility exists; but in what this peculiar and strange susceptibility consists, essentially, has never been explained. All that can be predicated when it makes its appearance is that it exists. In the spontaneous form of keloid we have the disease manifesting itself without any apparent cause or reason. It suddenly makes its appearance in the form of a small tumor, somewhat elevated, and it gradually enlarges until it reaches its limit of growth, where it remains stationary. In the meantime other keloids may be developing, so that it is not unusual to find a number of tumors in various stages of growth. As in the traumatic form, there exist marked subjective symptoms of a most painful and disagreeable character.

The histopathology of the various forms of keloid and pseudo-keloid cannot be entered into at this time, as the subject is one whose thorough

consideration would require much more space than could be spared at this juncture. Suffice it to say that it is a connective-tissue new growth which differs essentially from true scar, hypertrophic scar, or fibroma, in the peculiar distribution of the fibers of connective tissue.

The treatment of keloid is as yet an *odium medicinæ*. All the various methods which have been devised up to the present time have proven absolute failures, with the possible exception of one, and this is only claimed to have produced fair results in but a few exceptional cases. Excision is totally powerless, and is invariably followed by a relapse. The same is the result of the employment of the actual cautery, galvano-cautery, or chemical caustics. Each and every one produces a wound which, as soon as it cicatrizes, is again the seat of a keloidal tumor. Electrolysis is reported to have cured a few cases, but as there have been no reports forthcoming detailing the condition of the so-called cured patients, one or two years later, no positive reliance can be placed in such reports, more especially in view of the fact that the authors have noted relapses in patients treated by this method. For this reason the physician whose aid is sought in such cases should always be careful not to make promises or even hold out any marked encouragement to patients afflicted with keloid.

What may be done is to allay or mitigate the intense pain which manifests itself, and this may be accomplished by causing cocaine to traverse the tumor by means of cataphoresis. If this is not possible, a good application is the following, to be rubbed in frequently:

℞	Cocaini muriat	gr. xv
	Eng. aquæ rosæ	ʒ ij
	Lanolini	ʒ vj
M.		

Hypodermics of cocaine will also help to a marked degree and do much to allay the pain.

The prognosis in every case is always bad, and no hopes of ultimate recovery from keloid should ever be held out in the present condition of our knowledge of its therapeutics.

UNTOLD.

I toiled all day in an ice house,
 Storing the blocks away,
 And talked with their voiceless crystals,
 That I sought to keep from decay.

I asked them of their journey,
 Of a thousand things that day—
 And they drew me pictures from memory
 As I placed the blocks away.

And they told me many a story,
 And legends quaint and old;
 But the rarest things they told me
 Will never be retold.

RALCY H. BELL.

THE SHORT-TIME TREATMENT OF INEBRIETY.

By H. A. RODEBAUGH, M. D., of Marysville, Ohio.



UNDER the present state of our science, the time required in the treatment of any disease depends upon our idea of its pathology, etiology, and the results previously secured by any given treatment in similar cases. Within certain limits, this time varies with the age, sex, habits, and constitution of the patient.

Inebriety, or alcoholism, is a specific, neurotic disease, caused by the previous use of alcohol. Its pathology relates to changes in the nerve cells, whereby normal function is at first embarrassed and later abolished. In inebriety, as in many other diseases, important changes in theory have occurred from time to time in regard to its cause, effect, and cure. Many years elapsed before the profession recognized inebriety as a disease, then later as a form of nervous disease. Following its recognition, came all kinds of theories in regard to its pathology. Previous to 1828, the uncontrollable craving for stimulants, which really constitutes this a distinct disease, was believed to be due to some pathological change in the stomach, and treatment directed accordingly. Subsequently, it was taught that alcoholism consisted in the grosser lesions found in the various important organs of nutrition in those suffering from this disease; and that, to be successful, treatment must be continued for months or even years. We now know that these various lesions of the brain, stomach, kidneys, liver, etc., are products, not factors. From the earliest period of which we have any account, all students and observers of inebriety have agreed that the disease is never developed except in those individuals who had previously used alcohol in some form for any purpose whatever, and that its use must have been continued for some time. Alcohol is a poison, and the phenomena of inebriety are due in the first place to the direct action upon the nervous system of this agent. If we surround a living nerve with alcohol, we find that it becomes paralyzed; that is, incapable of transmitting impressions through its submerged part. Similarly, if an animal absorb into its circulation a certain quantity of alcohol within a given time, the nerve centers and the peripheral nerves become paralyzed. This may be called the direct effect of alcohol: It has also been ascertained that the impregnation of the blood with alcohol interferes with its absorption of oxygen. It thus becomes unfitted to support healthy nervous function. Under these combined influences, the nervous tissues, especially those of the central organs, become more and more unfitted for the painless performance of their proper functions. These changes progress with a rapidity proportionate to the quantity of alcohol used and the susceptibility of the subject

to its influence. These effects are counteracted partially by the elimination of portions of the alcohol from the system, which goes on by the medium of all the excreting glands, especially the kidneys, skin, and lungs. It is important to bear these facts in mind, in order to appreciate what is meant by cure.

Inebriety is more quickly developed by the moderate use of alcohol in neurasthenics, in social drinkers, who eat too much and exercise but little; in those who are much exposed to the depressing passions, those who undergo great fatigue of body or mind, especially if unsuccessful in their pursuits; those who inordinately indulge the passions of anger and lust; and, finally, those who habitually swallow patent medicines, whose chief ingredient is alcohol. There is an immutable association in the mind of every drunkard between stimulating liquors and the relief they afford to all the unpleasant sensations, physical and mental, which are inseparable from the every-day life of one who has learned to lean upon the alcoholic crutch. The accustomed drink, when taken, produces an instant change from pain to pleasure, from despair to hope, and transforms this thorny, rugged wilderness of a world into a paradise. To cure such an individual, we must break up this association, and convince him by actual sensations that his remedy has lost its effect and that he no longer experiences the same pleasurable sensations.

In discussing the treatment of this disease, it is important to remember that the general principles of treatment applicable to any disease also apply here. Diseases are cured, when they can be cured, by their natural biological evolution. Our ordinary therapeutic methods consist in removing the cause, then putting the organism in such a condition that the *restitutio ad integrum* may take place. We suppress pain, we modify function, we let diseased organs rest, we calm fever, we retard the pulse, we induce sleep, we incur secretion and excretion, and acting thus, we permit nature, the healer, or, to speak in modern language, "we permit the activity of the forces and the properties inherent in the biological elements to accomplish their work."

In the treatment of inebriety, the best results are obtained if the individual be removed from his home and placed among strangers. No amount of contriving can offer the patient the same care at home that can be had at properly conducted institutions, while the moral effect of association with others of his class is not without benefit. The next step essential to a cure will be to discontinue the use of alcohol. This object may be attained either by physical, chemical, or psychical restraint. With our knowledge of modern methods, physical restraint is no longer necessary. Chemical restraint is secured by the administration of drugs whose primary effect is to create an indifference to both the taste and effect of alcoholic stimulants, so that within a few days the inordinate craving for drink is abolished. This result is said to be secured also by those who practice suggestive therapy. Burnheim, Soltan, Rice, Burr, and many others, have secured excellent results by this method. I have had no personal experience with suggestive therapy alone, but, combined with suitable medication, I know that excellent results are secured.

We must remember that a cure consists, first, "in breaking up the association in the mind of the drunkard between alcohol and the relief it

affords to all his unpleasant sensations." There will then be complete absence of the drink crave, restoration to normal function, including the will, rapidly followed by a complete change in the physical, mental, and moral condition of the patient, resulting in normal appetite for food, sound, refreshing sleep, and improved nutrition. Morally, the change is manifested in an aversion to the society of a drinking companion, pride in personal appearance, a rekindling of love for home and family, with returning interest in business affairs. We know that these changes can be wrought in a comparatively short time, so that the patient may be discharged with the assurance that nature will complete the cure in time. Securing proper environment of the patient subsequent to treatment, upon which depends the permanency of the cure, does not come within the province of the physician.

One of the elements of success in the treatment of inebriety, either by drugs, suggestive therapy, or a combination of the two, is tact in the management of the patient at the beginning of treatment. Elimination is necessary in all cases. Cathartics, diuretics, diaphoretics, and baths must be used as required. The selection of remedies suited to each individual case must depend, not only on the condition of the patient, but the facility with which they can be administered and the certainty of absorption. This brings us to the consideration of hypodermic medication, without which the treatment of inebriety would indeed be difficult, if not impossible. Solutions for hypodermic use, if prepared antiseptically, may be kept several weeks by the addition of boracic acid. Remedies thus used are pilocarpine, theine, nitro-glycerine, duboisia, spartein, picrotoxin, and atropin, and cocaine combined, the latter possessing a peculiar hypnotic effect which cannot be secured from either drug when administered alone. Strychnia and apomorphia are never used. These remedies, with the exception of spartein, are used only for brief periods to meet special indications. Thus, spartein and nitro-glycerine combined, are used in cardiac depression; picrotoxin in cases characterized by excessive tremor; and pilocarpine to assist elimination; sulphate of spartein, on account of its valuable tonic properties, is continued throughout the treatment. Remedies for internal use consist of alteratives and tonics. Recently the gold salts have been largely used, either alone or combined with other mineral alteratives of the class which increase waste. Abundant clinical experience has demonstrated the value of the gold salts in all forms of nervous diseases characterized by sclerosis. These drugs should be administered in small and frequently-repeated doses, in solution with a definite quantity of tannin to form tannates, and thus prevent injurious local action, at the same time securing slow absorption and adequate elimination.

Diet, in the treatment of inebriety, is highly important. The administration of proper food at regular intervals, day and night, materially assists in abolishing the drink crave.

I believe that many physicians fail to secure the best possible result in many cases of inebriety because they forget that body and mind are so closely related that when the one suffers the other must share the suffering, and the injury to the physical health, the pathological side resulting from drink, must be accompanied by similar injury to the mental and moral powers. Degeneration of tissue and organic changes in nerve cells more

palpable than degeneracy of morals, a cirrlosed liver is more startling than a breach of faith, but the deeper fact, of which the senses take no note, is the more important one, and should be recognized by every physician who assumes charge of this class of cases. The phenomena to which we refer, often manifest themselves to the quickened perceptions of those who stand nearest the inebriate. Many a mother observes with a heart that grows heavier day by day the signs of moral decay in the character of her son. It is not the flushed face and the heavy eye, the foul breath and unsteady gait, that troubles her most; it is the evidence that his mind is becoming duller and fouler, his sensibilities less acute, his sense of honor less commanding. Near the close of treatment, during a confidential talk, in which the patient will boast of his splendid physical condition, the physician would say to him, "Yes, you are cured. It is true that you are not now a drunkard; it depends upon yourself whether you ever will be or not. If you could know what was painfully evident to those who love you best, how your character, when you first began drinking, slowly lost the fineness of its texture, firmness of outline, and how your art deteriorated in the delicacy of your touch, how the very atmosphere of your life seemed to grow murky, you would never, for a moment, entertain the thought that a drink would do you good."

The usual result secured in the average patient in a period of four weeks' treatment is, first, protection of the patient against himself and restoration of his will power, so that a further aggravation of his trouble by the continued use of alcohol will be prevented; then, by suitable treatment, we endeavor to restore him to an approximately normal physical condition. While this short period of treatment is criticised by many who have been engaged in this work for years, and whose opinions are entitled to consideration, it must be remembered that it is utterly impossible for the great majority of inebriates to avail themselves of treatment at an institution where one year or more is required. An unprejudiced comparison of results, however, will not be found unfavorable to the short-time treatment.

About Substitution.—The medical profession recognize the necessity of correct diagnosis, but should not forget that the public estimate the doctor's skill, not by his familiarity with technical details, but by actual results. See to it that your prescriptions are filled as written.

If the druggist found that every attempt at substitution cost him the physician's patronage, he would soon become tired of it, and would supply exactly what prescriptions call for.

The substitution of one article for another is a crime alike against physician and patient. The medical profession can put an end to it by sending their prescriptions only to those pharmacists around whom there rests not the slightest suspicion.

No matter how great may be the ability of the practitioner as a diagnostician, the patient receives no advantage if the preparations administered are of indifferent quality.—*Therapeutic Gazette.*

SUPERNUMERARY FINGER GROWING FROM FIRST METACARPAL BONE.

By JOSEPH C. HUGHES, M. D., of Keokuk, Iowa.

Professor of Surgery in the Keokuk College of Physicians and Surgeons.

The accompanying cuts show a condition found in a young man who recently consulted me. The condition was symmetrical. The extra fingers were made up of three phalanges each, and flexion and extension were perfect. Dissection showed true joints.



FIG. 1. Dorsal Surface of Prof. Hughes' Case of Supernumerary Finger Growing from First Metacarpal Bone.



FIG. 2. Palmar Surface of Prof. Hughes' Case of Supernumerary Finger.

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THE SAINT LOUIS ACADEMY.

The Saint Louis Academy of Medical and Surgical Sciences was established on the evening of November 6, 1895. That such an organization was and is needed will be conceded by all who are familiar with the needs of medical Saint Louis. The constitution of the new society subscribed allegiance to the American Medical Association. The requirements for membership are such as will exclude the illiterate doctor, the self-seeking medical politician, the drones, and those unfortunate individuals who are seeking a row. Two negative votes will defeat a candidate. The membership in the Academy is limited to fifty.

Although less than two years old, the Academy has done much for medical Saint Louis. It has bound together a number of young men of ability, who are congenial and present a united front on every question of vital importance to the profession. The Academy has gone on record as being opposed to the existence of fifty-cent hospitals; it is opposed to the abuse of medical charity; it is in favor of a higher standard of medical education. It is opposed to trickery, fraud and deceit. It has established the only medical library in Saint Louis which is owned and controlled by medical men. It has produced and published more medical literature of a high grade than any medical society in this city. It has obtained recognition from the Missouri State Medical Association and from prominent physicians everywhere. To say that a paper has been "read

before the Saint Louis Academy of Medical and Surgical Sciences," is to give it a birthmark of value. The first year's officers were: President, Dr. George W. Cale; Senior Vice-President, Dr. James Moores Ball; Junior Vice-President, Dr. Arthur E. Mink; Secretary, Dr. Emory Lauphear; Treasurer, Dr. Wellington Adams; Orator, Dr. Thomas Osmond Summers; Curator, Dr. George Howard Thompson. The second year's officers were: President, Dr. Otto Sutter; Senior Vice-President, Dr. Carl Pesold; Junior Vice-President, Dr. G. C. Eggers; Secretary, Dr. Ozias Paquin; Treasurer, Dr. Floyd Stewart; Orator, Dr. Thomas Osmond Summers; Curator, Dr. Emory Lauphear; Librarian, Dr. A. H. Ohmann-Dumesnil.

What the Academy Needs. The Academy asks for contributions of books and book-cases; for complete files of medical journals, and for works of reference.

A receipt duly signed by the Librarian is given to every donor. Among the journals wanted are the following: *British Medical Journal* from beginning to 1897; *London Lancet*; *American Journal of Ophthalmology* from beginning to 1896; *The Asclepiad*; *Journal of the American Medical Association* from 1888 to date; *The Practitioner* (London); *The Annals of Surgery* from 1885 to date; *The American Journal of the Medical Sciences*; *Johns Hopkins Bulletin*; *Medical Record* before 1887; *New York Medical Journal*; *Annals of Anatomy and Surgery*.

THE CITY HOSPITAL.

The Saint Louis City Hospital is a temporary affair, and is open to much criticism as concerns the building and surroundings. As far as the management is concerned, it is above reproach. We doubt if there are many individuals who could do as well as Doctor Sutter has done under unfavorable circumstances. He has entered into the work with a spirit that commands success; has mastered every detail, and he works more hours a day than any physician in this city. Yet he is not free from criticism. Every few weeks the *Republic*, which seems to delight in stirring up the local profession, prints an anonymous attack upon the hospital, the law under which it is managed, the superintendent, and all who happen to be consultants to the institution.

Anonymous Attacks on the City Hospital. The object of these attacks is not apparent at first sight, but a close inspection shows that somebody is after the Health Commissioner, Doctor Max Starkloff, and Superintendent Sutter. A closer study of the question shows that all the anonymous attacks come from the same source—a surgeon who happens to teach in the medical department of a local university. He never attacks fairly and openly, but fights in the dark. He never criticises the management of the Female Hospital and Insane Asylum, for they are managed by his followers; but because he cannot turn the City Hospital into a proselyting institution for his ancient (and honorable?) medical school, he resorts to anonymous attacks. We will not dignify this mud-slinger by mentioning his name.

THE MONTREAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

The sixty-fourth meeting of the British Medical Association was held in the city of Montreal last month. Over eight hundred physicians registered, and perhaps as many more were present who did not register. The hotel accommodations were insufficient. The general addresses were not what one would expect from such a great society. Many small medical associations in this country equal them at every annual meeting. There seems to have been nothing new in them. Even the address in surgery, upon a historical subject, presenting as it did the opportunity for research, was a tame affair. The medical politicians were much in evidence and degrees were conferred on some "carefully selected gentlemen, though not at all to the taste of the great mass of the body." Socially, the meeting was a success.

THE MOSCOW CONGRESS.

The International Medical Congress which was recently held in Moscow was a success. Many of our readers, however, will probably be surprised to learn that the meeting at Moscow was attended by upwards of 7000 members. From this point of view, no doubt the Congress was a success, but deplorable difficulties seem to have been experienced, as perhaps was natural under the circumstances, of finding accommodation for all the visitors. On the other hand, the Russian hosts seem to have vied with each other in their display of hospitality to their guests, and for this reason many of the latter who were present will look back with much pleasure to their visit to the great Russian city. The next Congress will be held in Paris in 1900, the year of the forthcoming French exhibition. With the additional attraction of the latter, the thirteenth great annual *reunion* should prove to be a phenomenal success.

FERRATIN IN AMENORRHEA.

In a clinical report on the value of ferratin in anemic conditions, Dr. C. Earle Williams (*Amer. Therapist*, August, 1897) reports the following interesting case, typical of frequent occurrences in general practice:

T. P., age 19. Came under my treatment May 10, 1897. She had not menstruated for five months. Her complexion was chlorotic, with large, dark rings around the eyes. There was dyspnoea and palpitation on the slightest exertion, constipation sometimes lasting seven days. Vicarious secretion was represented by frequent nose bleed. Blood count showed red cells 3,000,000, hemoglobin fifty-two per cent. She was placed on ferratin, gr. viij, four times daily, with aloetic purges, combined with perfect rest. June 15th: great improvement in every way. Red cells 3,700,000 per ccm., hemoglobin sixty-five per cent. The dose was increased to gr. xij, four times a day, unintermittingly until August 1st, resulting in complete recovery. All the distressing symptoms had left; menstruation returned, quantity and quality good; red cells 4,600,000, hemoglobin ninety-two per cent.

Referring to purges, the author suggests the following combinations with ferratin:

- | | | |
|-------|--|----------|
| 1. ℞ | Ferratini..... | ʒ ij |
| | Rad. rhei pulv..... | ʒ iv |
| | Sodii bicarb..... | ʒ ij |
| | Ol. foeniculi..... | gtt. xxx |
| M. S. | Take a teaspoonful in water, or dry into the mouth, and wash down with a draught of water or other liquid. | |
| 2. ℞ | Ferratini..... | ʒ iij |
| | Extr. aloes..... | gr. xiv |
| | Extr. rhei comp..... | gr. ix |
| M. S. | Make into 30 tablets; take 1 or 2 tablets twice daily. | |

Dr. Williams' report, covering six varying cases in detail, is a practical paper of general interest.

DERMATOLOGY AS PRACTICED IN PROFESSOR UNNA'S CLINIC.

In our next issue we will print a valuable paper which was recently read before the St. Louis Academy of Medical and Surgical Sciences by Doctor M. F. Engman, Lecturer on Dermatology in the Marion-Sims College of Medicine, and former Assistant to Professor Unna. Doctor Engman gives an interesting and valuable account of this renowned clinic. A portrait of Professor Unna will accompany the article.

THE TRI-STATE MEDICAL SOCIETY.

The next meeting of the Tri-State Medical Society of Iowa, Illinois and Missouri will be held in Dubuque, Iowa, early in April, 1898. A valuable program will be prepared. The growth of this excellent society has been phenomenal. Dubuque is the metropolis of Northeastern Iowa, Southeastern Minnesota, and the adjacent part of Illinois and Wisconsin. The city is well provided with hospitals, and no doubt advantage will be taken of this fact to hold some of the splendid clinics for which this society has become famous. The physicians and surgeons of Dubuque are an honor to the profession. We predict a large attendance and a harmonious meeting. As arrangements progress, the JOURNAL will keep its readers informed.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

As we go to press the indications point to a large attendance at the Louisville meeting. The society will hold its sessions on October 5th, 6th, 7th and 8th, 1897. Many St. Louis doctors will attend, and almost all will travel over the B. & O. S.-W. Railway. Tickets can be procured at 105 North Broadway, where Mr. W. P. Townsend will give all details and information. The profession in Louisville always does the honors with credit to the State of fair women, fast horses and good cheer.



IN THE PROFESSIONAL EYE

DOCTOR JAMES MOORES BALL, SENIOR.

At 1:45 o'clock on the morning of August 26, 1897, at his rural home on the Blue House road, a short distance outside the city of Waterloo, Iowa, occurred the death of Dr. James Moores Ball, Senior, at the advanced age of 85 years. The doctor had been in poor health for some time, the ailment being a general wearing out of his physical system. He suffered much during the final severe illness, but the end was peaceful, and at that time he inquired after each member of his family, both present and absent, and expressed his confidence in a future reunion in the world beyond.

Dr. Ball's life was one full of interest; and his activity in serving his fellow-men, both in times of war and of peace, endeared him to all. His history is a grand one; he was an upright Christian man. He was born on the 11th of May, 1812, in Salem, Jefferson county, Ohio, the son of Farlin and Elizabeth (Moores) Ball. The Balls are of Scotch and Quaker ancestry; seven brothers and one sister came over from Scotland in the days of Wm. Penn, and settled in Philadelphia. The great-grandfather of Dr. Ball removed in early life to Loudon county, Virginia. He was a cousin of Mary Ball, the mother of George Washington. Ball's Bluffs and Ball's Cross Roads, now famous in American history, took their names from this family.

Dr. Ball completed his literary studies at a college in Richmond, in his native county, and at the age of twenty commenced his medical studies in the same place, with Dr. William Farmer. He graduated from the medical department of Western Reserve College at Cleveland, Ohio.

Dr. Ball followed his profession in Ohio until 1849, when he moved to Monroe, Green county, Wisconsin, and there continued the same until 1866, obtaining a wide reputation as a skillful physician and surgeon. In the last-named year he removed to Iowa and practiced six years in Waverly, Bremer county. He removed to Waterloo in September, 1872, where for ten years he enjoyed a large practice. About fifteen years ago he abandoned active life and retired to the rural home just outside the city where his declining years have been quietly passed.

In the late war, Dr. Ball occupied every position on the medical staff of the United States army, from assistant surgeon to that of medical director of district. He was first commissioned assistant surgeon of the Thirty-first Wisconsin Volunteer Infantry. He was detached from his regiment by order of George Van Cleve, to take charge of a hospital and prepare others for refugees, in Murfreesboro. He was ordered to report to his regiment, and in July, 1864, obtained a leave of absence of General Sher-

man, and soon after his return home was commissioned surgeon of the Forty-fourth Volunteer Infantry, but being unfit for field duty was ordered to Camp Randall, Madison, Wisconsin, to make primary examinations. He was afterward ordered to report to General Thomas, at Nashville, Tennessee, later General Palmer, and then to General Meredith, at Paducah, Tennessee, where he was appointed surgeon in charge of that post, and soon after of the district of Paducah. On the 28th of August, 1865, he was mustered out of the service.



Dr. Ball in his Eighty-third Year.

He was a Royal Arch Mason. In his religious sentiment he was a Methodist; in politics he was a Republican since that party was organized.

On the 4th of March, 1832, he was married to Miss Keturah Ford, and by her had four children, two of whom—W. H. Ball, of Yankton, S. D., and Judge Farlin Q. Ball, of Chicago, are living. Mrs. Ball died in 1860.

On the 9th of October, 1861, Dr. Ball was married to Miss Martha G. Glover, of Green county, Wisconsin, and by her also had four children, Dr. James Moores Ball, Jr., and Dr. Otho F. Ball, now residing in St. Louis, and Frank E. Ball and M. G. Ball, of Waterloo. The wife is also living.

Such is the brief record of the life of one whose heart was filled with the milk of human kindness and whose days were spent in the service of

his fellow-men. Only those who have the honor to be his children know how much Dr. Ball did for charity. The night was never too dark, the storm never too severe, to keep him from responding to the call of the sick and wounded. It mattered not whether the patient was a pauper or a rich man, the service was as carefully and quickly rendered to the one as the other.

Dr. Ball was a man of splendid nerve. In his seventy-fifth year his hand was as steady as that of a youth. His clear, blue eye and active brain could comprehend a situation instantly. Many a poor soul owes his life to Dr. Ball's dexterity. At a time when surgery was synonymous with rapidity, Dr. Ball scored some of his greatest triumphs. I well remember when a lad of fifteen assisting him in an amputation of the thigh. The flaps were made and the bone sawed off in less than fifty seconds! On one occasion, while traveling across the plains to California, Dr. Ball came upon a wounded man, who had been placed in the shade of a tree with a jug of water and a small amount of food placed by his side. He had been deceived by his partner, who stole the horses belonging to the two. In the fracas a pistol bullet had passed through the patient's knee-joint; and he had been left to die. Dr. Ball, unaided and alone, gave the man chloroform, amputated the thigh at the lower third and hauled the patient seventy miles into Salt Lake City, where he made a good recovery. This was only one of many good deeds done without expectation or hope of reward.

Dr. Ball left only a small estate, but there remains to his children something better than riches—a good name, and the record of a life well spent.

Dispensing Physicians can save money by dealing direct with the manufacturer. Why don't you make the profit now paid the middleman? Mail us your orders. We are the base of supply—we manufacture everything in the pharmaceutical line. We give physicians forty per cent. discount from the usual list—other houses give you twenty-five per cent. We deliver freight orders free of charge. Goods guaranteed. Try us once and see what you save. Catalogue on request.

THE MERCER CHEMICAL CO.,
Manufacturing Chemists,
OMAHA, NEB.

New Hospital.—The trustees of the Protestant Hospital in East St. Louis expect to build next summer. The new hospital shall have a capacity of about seventy-five or eighty patients. This will almost triple the present capacity. The cost of the new building is estimated at \$25,000. The site, it is thought, will cost about \$8,000 or \$10,000. The hospital will be completely equipped with all modern improvements, and all appliances to aid modern surgery. It is expected that work will be commenced by early spring.



Diseases of the Ear, Nose and Throat, and Their Accessory Cavities. A Condensed Text-Book. By SETH SCOTT BISHOP, M. D., LL. D., Professor in the Chicago Post-Graduate Medical School and Hospital; Surgeon to the Illinois Charitable Eye and Ear Infirmary. Illustrated with 100 colored lithographs and 168 additional illustrations. One volume, royal octavo, pages xvi—496. Extra cloth, \$4.00, net; sheep or half-Russia, \$5.00, net. The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street, Philadelphia; 117 W. Forty-second Street, New York; 9 Lakeside Building, Chicago.

We have found Dr. Bishop's book interesting and can recommend it to all who need a concise treatise on the ear, nose and throat.

A System of Practical Medicine. By American Authors. Edited by ALFRED LEE LOOMIS, M. D., Late Professor of Pathology and Practical Medicine in the New York University, and WILLIAM GILMAN THOMPSON, M. D., Professor of Materia Medica, Therapeutics and Clinical Medicine in the New York University. To be completed in four imperial octavo volumes, containing from 900 to 1000 pages each, fully illustrated in colors and in black. Vol. I. Infectious Diseases. Just Ready. Vol. II. Diseases of the Respiratory and Circulatory Systems, and of the Blood, Kidneys and Genito-Urinary Organs. Just Ready. Vol. III. Diseases of the Digestive System, of the Liver, Spleen, Pancreas and other Glands. Gout, Rheumatism, Diabetes and other Constitutional Diseases. In Press. Vol. IV. Diseases of the Nervous System and of the Muscles. Diseases of Doubtful Origin, Insolation, Addison's Disease, etc. In Active Preparation. For sale by subscription. Per volume, cloth, \$5.00; leather, \$6.00; half morocco, \$7.00. Lea Brothers & Co., Publishers, Philadelphia and New York.

The second volume of this representative American System of Medicine follows the first after an interval brief enough to satisfy the large number of readers who are awaiting each issue with expectancy. It considers the diseases of the respiratory and circulatory systems, of the mediastinum, of the blood, of the kidneys, of the bladder and the prostate gland, and is amply illustrated with engravings and plates. In adherence to the design of the work, the practical aspects of medicine have received complete consideration in conformity with the most advanced and accepted views. The editors have received the willing assistance of the leaders of American medicine, and have therefore been able to assign each subject

to an acknowledged authority. The work is particularly full in the details of treatment, directions being given with such explicitness that the physician will have no difficulty in selecting from the abundant prescriptions and formulæ those most applicable to the special features of the case before him. The work is, in a word, a complete and authoritative statement of the practical part of medicine as it stands to-day.

A Practical Treatise on Medical Diagnosis. For the Use of Students and Practitioners. By JOHN H. MUSSER, M. D., Assistant Professor of Clinical Medicine, University of Pennsylvania, Philadelphia. New (2d) edition, thoroughly revised. In one octavo volume of 925 pages, with 177 engravings and 11 full-page colored plates. Cloth, \$5.00; leather, \$6.00. Lea Bothers & Co., Publishers, Philadelphia and New York, 1896.

That Professor Musser's work has easily achieved the foremost place as a full and systematic treatise on the practical side of its most important subject, is evinced by the prompt exhaustion of the first edition. The author has taken advantage of this opportunity to give his work a thorough revision and to incorporate in it a full account of all trustworthy advances that have been made in its department, one of the most progressive in medicine. Every page shows evidence of revision and the work is enlarged not only in text, but also in illustration, numerous handsome engravings in black and many full-page plates in colors being added. The position of *Musser's Diagnosis* is assured as the leading text-book for students and equally the best reliance of the physician.

Eye-Strain in Health and Disease. With Special Reference to the Amelioration or Cure of Chronic Nervous Derangements Without the Aid of Drugs. By AMBROSE L. RANNEY, A. M., M. D., Author of "Lectures on Nervous Diseases," "The Applied Anatomy of the Nervous System," "A Treatise on Surgical Diagnosis," "Practical Medical Anatomy," etc.; Late Professor of the Anatomy of the Nervous System in the New York Post-Graduate Medical School and Hospital; Late Professor of Nervous Diseases in the Medical Department of the University of Vermont, etc. Illustrated with thirty-eight wood engravings. Philadelphia, New York, Chicago. The F. A. Davis Company, Publishers, 1897.

The subject of eye-strain is one to which Dr. Ranney has devoted much study. The volume comprises the substance of several journal monographs written by him during the past ten years, with considerable new matter. The close relationship of eye-strain to headache and neuralgia, insomnia, chronic gastric and digestive disorders, chorea, epilepsy, nervous prostration and insanity, and abnormal eye conditions, are clearly proven and confirmed by numerous clinical histories of illustrative cases. For the best of reasons the reviewer is entirely in accord with the author as to the exceeding great importance of heterophoria and ametropia in derangements of the nervous system. The best and latest tests of vision and ocular movements are fully yet simply described, as also is the most approved surgical treatment for anomalies of the ocular muscles. The

very satisfactory results obtained from removing or counteracting the eye defects were all the more noteworthy because no medicine whatever was used in conjunction. We commend the work as one that can be productive of much actual service to humanity.

The Doctor's Window.—This is the title of a work of much interest to the profession, edited by INA RUSSELLE WARREN, for several years the editor of *The Magazine of Poetry*. It consists of poems by the doctor, for the doctor, and about the doctor, selected from a wide range of authors, from Chaucer to the present time, not neglecting Field, Carleton, Riley, Foss, Holmes and other favorites. The mechanical part of the volume will be first-class. The type was cast especially for the book, the paper will be hand-made deckel, and the size of the volume 7x9 3-4 inches. It will include several photogravure engravings, and will extend to about 300 pages. The publisher desires to place a descriptive circular in the hands of every physician and druggist in this country, and a postal card will be promptly answered by him.

We understand that the book is to be put on the market by the subscription plan, either direct from the office of publication, or through traveling representatives who will handle the book in conjunction with some staple article. The publisher is Charles Wells Moulton, of Buffalo, N. Y.

Reference Book of Practical Therapeutics.—By Various Authors. Edited by FRANK P. FOSTER, M. D., Editor of the *New York Medical Journal*, and of Foster's Encyclopedic Medical Dictionary. In two volumes. Vol. II. New York: D. Appleton & Co., 1897.

The second volume of this work is, if possible, superior to the first one. The contributors to Volume II. include the following names: Samuel Treat Armstrong, Edward Bennet Bronson, Samuel M. Brickner, William B. Coley, Floyd M. Crandall, Jeremiah T. Eskridge, Matthias Lanckton Foster, Arpad G. Gerster, Henry A. Griffin, Charles Jewett, Howard Lillenthal, Russell H. Nevins, Austin O'Malley, George L. Peabody, Frederick Peterson, Samuel O. L. Potter, Charles Rice, Solomon Solis Cohen and James T. Whittaker. Among its special features are exhaustive and carefully compiled articles on serum therapy, X-rays, nucleins, thyreoid treatment, rest-cure, mineral waters and baths. A valuable supplement brings into ready service the very latest journal contributions to therapeutic literature.

Tri-State Medical Society of Alabama, Georgia and Tennessee.—The Tri-State Medical Society of Alabama, Georgia and Tennessee will meet in the Senate Chamber of the State Capital at Nashville, Tenn., Tuesday, Wednesday and Thursday, October 12th, 13th and 14th, 1897. The programme is a most interesting one and the success of the meeting is assured. Reduced railroad rates to the "Tennessee Centennial." Frank Trester Smith, M. D., Chattanooga, Tenn., is the Secretary; F. F. Westmoreland, Atlanta, Ga., President; W. D. Haggard, Jr., M. D., Nashville, Tenn., Chairman Committee of Arrangements.

HISTORICAL SKETCH.

REALDUS COLUMBUS.

By JAMES MOORES BALL, M. D., of St. Louis.

The first anatomical treatise containing an account of the lesser, or pulmonary circulation, was the monumental work, *De re anatomica: libri xv.*, written by Realdus Columbus and sumptuously published at Venice in the year 1559. This, however, was not the first printed account of the lesser circulation. Six years prior to the publication of the book of Columbus the unfortunate Servetus, in a theological treatise, described correctly the course of the blood in its transit through the lungs. Tried for heresy, Servetus was burned, together with all obtainable copies of his book. Although it had been printed, the work was suppressed; hence it follows that Columbus was the first to publish the great discovery. Of the life of this anatomist we know but little. Born at Cremona, a small Milanese village, the year of his birth is unknown. He died in 1559, while his book was being printed. A few copies must have been finished before his demise, since a copy belonging to the late Dr. George Jackson Fisher, of Sing Sing, N. Y., contains the author's own dedication to Pope Paul IV., while in another exemplar, similar to my own, the dedication has been written by the two sons of Columbus, and is addressed to "*Pio VIII., Pont. Max.*" This pontiff, on the death of Paul IV., on August 18, 1559, became the head of the Church.

Some writers have held that the discovery of the lesser circulation was not made by Columbus independently of Servetus, but that a copy of the book of Servetus had drifted into Italy and had been read by Columbus. There being no direct evidence to support this view, we must hold that Realdus Columbus, the careful anatomist and celebrated physician, made the discovery independently of the unfortunate medico-theologian. When Vesalius was called to Madrid as physician to Philip II., Columbus, in 1544, succeeded him in the University of Padua; two years later he filled the anatomical chair at Pisa, and in 1546 Pope Paul IV. called him to Rome. Here he spent the later years of his life, engaged in teaching anatomy and writing his book. For forty years Columbus pursued his anatomical studies, and in that period dissected an unusually large number of bodies. Fourteen subjects passed under his scalpel in a single year. Columbus frequently made experiments upon living animals. He was the first to use dogs for such purposes, preferring them to swine. Book XIII. of the work of Columbus is upon the subject of vivisection: *De viva sectione*. In this he tells us how to employ living dogs in demonstrating the movements of the heart and brain, the action of the lungs, etc. Columbus was the first who demonstrated experimentally that the blood passed from the lungs into the pulmonary veins. "When the heart dilates," says Columbus, "it draws

natural blood from the vena cava into the right ventricle, and prepared blood from the pulmonary vein into the left; the valves being so disposed that they collapse and permit its ingress; but when the heart contracts, they become tense, and close the apertures, so that nothing can return by the way it came. The valves of the aorta and pulmonary artery opening, on



VENETIIS, Ex Typographia Nicolai Beuilacqua, M D LIX.
CVM PRIVILEGIIS.

Title-page of the Book of Columbus, 1559.

the contrary, at the same moment, give passage to the spirituous blood for distribution to the body at large, and to the natural blood for transference to the lungs" (translation of Willis: Wm. Harvey, pp. 90-91). Like Servetus, Columbus held to the idea of "spiritus." Harvey was the first

physiologist who recognized the circulation as purely a movement of blood. All before him assumed the existence of a mixture of air and blood. Columbus, pupil and prosector of Vesalius, like his great master, denied the existence of foramina in the cardiac septum. He says (*Lib. vii., De Corde et Arteriis, p. 177*): "Between the ventricles is the septum through which almost every one believes the blood passes from the right ventricle to the left, in order that it may be refined, during its transit, for the generation of vital spirits. But in this they are very far from the truth; for the blood is carried through the vena arteriosa to the lung and refined there, and thence, together with the air, it is brought away by the arteria venalis, to the left ventricle of the heart."

Columbus first described the duplications of the peritoneum; showed that the pleura consists of two layers; described the ventricles of the larynx, the omohyoid muscle, and the termination of the nerves in the muscles; gave an excellent description of the bones, cartilages, ligaments, muscles, heart, arteries, abdominal viscera, brain, nerves, etc.

The only illustration contained in the treatise of Columbus is an engraved title-page cut in wood, which we have had reproduced. It shows an anatomical theater in which Columbus himself is represented with bald head and long, flowing beard. Standing around the dissecting table are a number of interested spectators, looking at the abdominal viscera of a subject. It is a spirited old engraving. Many initial letters are found in the work.

Columbus was educated in medicine at Padua, where he listened to the lectures and saw the demonstrations of Andreas Vesalius. When Vesalius was called to Madrid as physician to Charles V. and his son Philip II., Columbus was chosen to fill the anatomical chair at Padua. At a later date the same position at Pisa was accepted by him. He was finally summoned to Rome by Paul IV., to whom his book was originally dedicated.

The following paragraphs of this sketch have been translated for our readers by one of the most scholarly members of the Saint Louis profession, and are interesting because they show the condition of anatomy over three centuries ago.

REALDI COLUMBI CREMONENSIS DE RE ANATOMICA LIBER XIII. DE VIVA SECTIONE.*

Whilst we studiously rely on an investigation of anatomy, some things occur which recall us in our course whose action we can know by no other method, unless we make use of vivisection. Not of men, however, as the ancients were accustomed, which to the Christian physician could but appear unlawful and impious, but of brutes—instead of dissecting the live human body, which the ancient physicians made use of to such an extent as to be heard of with so much execration that it was not allowed to even cut the cadaver of men much less to dissect the living man.

I think on account of this one cause Galen was lead to abstain from the dissection of the human cadaver. But, good Galen, if it seemed too cruel to you to cut the living man, and if your mind grew horrified, and if you dreaded, and if you were not permitted by the edicts of the rulers, to dissect the dead man, how is it lawful for you to inveigh against the ancients for cutting monkeys, since they cut the human body you yourself amply testify? Certainly, today, when popes, kings and rulers concede its usefulness on account of the common good to the living, and in the public academies how many anatomists teach dissections by dis-

* Translated by DR. L. CH. BOISLINIÈRE, of St. Louis.

secting the cadavers of criminals, it is easy to decide this controversy. In many places you censure the ancients, when you yourself are deserving of greater censure than they.

For even if the monkey has something similar to man, it is nevertheless a monkey and not a man; neither does its structure answer in every part to the construction of a man; for you see some parts in man, about which the ancient anatomist spoke, in which the monkey is wanting.

But let us return to our subject. Whilst we are forbidden by the Christian religion to dissect live men, if neither monkeys, nor bears, nor lions, are plentifully at hand, whose structure approaches most nearly to the human, and the cutting of whom alive is most difficult, when they are enraged, as they are wild beasts even though tamed, I shall speak of the dissection of the live dog. I choose, therefore, the dog, either the male or preferably the young female; for whilst a puppy is being cut he cries out more than an older one—it maybe on account of a rather long neck. I propose cutting the dog rather than the hog, as hogs are less adapted for use in distinguishing the reversive nerve. Then on account of the exuberant fat and on account of their noise and grunting, too ungrateful to the ears, which I at Cremona have found out, in this very matter that I might satisfy in this the excellent College of Physicians, and especially Ofredus, Macagnus, Manaa, Picenardus, Borgius, Bonettus. For when they have seen me dissecting the human cadaver, in the description of the whole anatomy, earnestly requested me to show them in the young hog, as in the live dog, the special organs of the voice, which I willingly have done, but it made so much noise that we would be deceived in our end.

Therefore the hog having been dismissed, the young dog may be chosen on account of its long neck; for the dog is an animal which forms and expresses its voice by barking. The table should be high and below be divided regularly by holes, and there should be sufficient bonds with which you may bind the four legs of the dog, and thus everything will be clear and orderly. The head is selected in such a manner that the dog can cry out some and not die.

Before you come to the vivisection, it should first be observed what the voice consists in, which is admirable; then you will consider the action of the lungs; then how the lung embraces the heart; then how it is that one part, striking the other part of the chest, remains uninjured—from which the use of the mediastrum is made clear. Besides, you may observe the movements of the diaphragm, which enlarges on inspiration and contracts on expiration. By this beautiful view it can be seen by the movement of the heart in what manner it dilates and contracts—likewise what is the nature of the movement of the arteries in live dissections; if you wish, you can see whether this motion is the same or opposed to the motion of the heart. You will ascertain that whilst the heart dilates the arteries are contracted, and again dilate in a contraction of the heart. You truly observe that whilst the heart is drawn upward it seems to be swelled, then it contracts when it liberates itself, as if turned downward relaxed; at this time the heart is said to be at rest. This, then, is the systole of the heart, because it bears up more easily and with less labor, but when it transmits it needs greater power.

Nor do not hold this tightly, for you will find not a few who certainly believe the heart to be dilated when it is really contracted.

Besides, you ought to note this: that every difference of pulse can be seen in the uncovered heart. Thus you can learn more in a short time from this section of the live dog than in many months from the pulsations of the arteries. Neither can you get so much pleasure or knowledge of the pulse from the book of Galen on the pulse in three whole months as you can by the inspection of one hour of the heart of the living dog. Besides, it can be seen how not only the heart, as all know, dilates and contracts, but the brain also, which fact is known to few. In section of the heart, when you first open the pericardium, carefully look at the aqueous humor in the pericardium, lest you should overlook it.

FORMULAE.

Chorea Minor.—Use the following as a sedative and antispasmodic for children of five to ten years.

℞ Lactophenini 0.15
 Quinin. hydrobrom 0.15
 M. Ft. chart. tales No. X.
 Sig. Take one powder three times daily.

For children of ten to fifteen years of age, use:

℞ Lactophenini 0.8
 Quinin. hydrobrom 0.8
 Butyr. cacao 10.0
 M. Ft. suppos. tales No. V.
 Sig. Use one suppository at bedtime.

—From “Practical Notes” in *Pediatrics*, p. 219, September 1, 1897.

Calculi in the Tonsils.—M. Porquet, of Paris, reports having extracted from the left tonsil of a child of thirteen a calculus the size of a large nut. Its color was yellowish and its form that of a pyramid. Analysis revealed the presence of phosphate of lime, of magnesia, and of carbonate of lime.

Ichthyol.—This valuable preparation has now for several years been before the profession, and has met with much favor for the treatment of various diseases. In dermatology especially, as first shown by Professor Unna, of Hamburg, it has proved of great service. Latterly it has been largely employed in the treatment of some ocular affections. Applied to the mucous membranes, experience has shown that ichthyol does not cause any discomfort; on the contrary, it seems to have a sedative effect. It may be used either as a lotion or as an ointment in cases of blepharitis and conjunctivitis, also in pannus, where it has been found

to effect much improvement. As the advantages of the application of ichthyol in these cases comes to be more widely known, the drug will tend to become still more popular.

Nervous Palpitations.—

Bromide of strontium } ʒj
 Bromide of sodium }
 Syrup of oranges ʒv
 One tablespoonful every morning in an infusion of valerian root.
 Hydrate of chloral ʒj
 Syrup of belladonna ʒj
 Syrup of oranges ʒiv
 A tablespoonful every night in milk.

—*Medical Press and Circular.*

Chinosol.—This new antiseptic and deodorant is supplied by Mr. B. Kühn, of 36 St. Mary-at-Hill, E. C., London, together with various preparations thereof. Chinosol, a yellow powder with a slight and agreeable aromatic odor, is readily soluble in water in all proportions, and though (as shown by comparative bacteriological investigations) vastly more powerful than carbolic acid and even corrosive sublimate, it is devoid of both caustic and poisonous properties. It is, therefore, pre-eminently a *safe* antiseptic and deodorant, and its use does not entail any danger either to tissues or to life.

Antitoxine as a Preventive of Diphtheria.—Mr. Lennox Brown’s opinion is unfavorable to the prophylactic efficacy of antitoxine. He says: “As a corollary, we might be able to pronounce that the power of antitoxic serum to ward off a possible attack of diphtheria is in proportion to the vigor and healthy blood con-

dition of the individual in whom it is employed; but the very minute dose administered for this purpose is evidently capable of being soon broken up by cellular action in the healthy.

"We can, therefore, understand the general admission as to the evanescent character of the immunity so attained. Moreover, reports of cases are not wanting in which noxious and even fatal results have followed the use of serum when employed as a prophylactic.

"On all these grounds, therefore, we do not feel justified in recommending serum for this purpose. More real methods of preventing the spread of diphtheria are to be found in improved sanitation, in prophylactic surgical treatment already detailed, and in efficient isolation and disinfection."

Constipation.—Abstain from administering cathartics in slight transient disturbances of digestion—let nature take her own course. Never put a patient on a one-sided diet for too long a time; the exclusion of vegetables, fruits, and starchy foods in general from the diet is frequently the cause of marked constipation. A hygienic mode of living, regular habits, less business strain and worry, and more outdoor life and exercise, are of great importance. The patient should be impressed with the importance of not worrying and bothering about his bowels; train him to have an evacuation once a day at a certain time, either giving no drugs whatever, or administering a very slight cathartic for a short period, then gradually diminishing and ultimately discontinuing its use.
—*The Post-Grad.*

Removal of Moles Upon Face and Warts Upon the Hands.—Dr. Arthur Barris Nelson, of San Francisco, says: I have removed from fifteen to twenty-five "moles" upon the faces of different individuals, and as many "warts" upon the hands by, the following treatment:

By the application of ethyl chloride or ordinary "Squibb's" ether in the form of a spray you endeavor to produce complete anesthesia of the growths and neighboring tissue. I next apply nitric acid (C. P.) with solid glass rod directly to growth. After several cauterizations (say three or four) the growth is destroyed and on a level with epidermis. If suppuration or sloughing of tissues is well marked, the application of peroxide of hydrogen for removal of pus is used. Then the parts are dusted with boric acid or "aristol." The wound soon heals, leaving little or no scar. I see no contra-indication for the use of nitric acid—and I use it in full strength fuming. It will not spread—its action is confined strictly to the area of application; however, extreme care should be exercised in using, as a drop will destroy and disfigure normal parts.

I have used the following in the treatment of "liver spots"—the skin trouble which is probably due to a vegetable parasite, *tinea versicolor*:

Resorcin	one dr.
Alcoholis	three drs.
Glycerini	one oz.
Aq. Rosæ	four ozs.

q. s. a. d.

M. Sig.: Apply with lint, two or three times a day.

The resorcin may be used in greater strength if required.—*Louisville Medical Monthly.*



Death of Doctor Rooney.—Dr. Michael Rooney, who died on September 10th, at his home in Quincy, Ill., of obstruction of the intestines, was one of the ablest and best-known physicians in Quincy, and for years had stood at the head of the medical profession in that city. Personally he was esteemed and admired as the friend as well as the physician. Quiet and unassuming in his tastes, nevertheless firmness was one of the dominating traits of his character. He was never hasty, yet when his mind was once made up it required much to change it. He was a director in the Quincy Public Library, and his comprehensive reading and wide knowledge of books were of inestimable value to that institution, and through it to the public. He was an omnivorous student, and his mind was stored with a vast fund of information, not only of his profession, but of general knowledge. He was 60 years of age, having been born in New York January 31, 1837. He came to Quincy July 5, 1871, and in 1875 was married to Dr. Abby Fox, who with two sons, Paul and Henry, survive him.

Dr. Buchanan Hatchett.—This gentleman, who has long been identified with the Arkansas profession, has removed from Ft. Smith to St. Louis. We predict that the Doctor will build up a large practice in this city.

The Illinois State Board of Health Raises the Standard of Medical Education.—At a meeting of the Illinois State Board of Health, held August 26th, at East St. Louis, it was decided to raise the standard of medical education of Illinois from three years to an obligatory course of four years. Moreover, in order to matriculate at a medical college in Illinois it will henceforth be necessary for students to pass an examination in all of the ordinary studies, algebra, as far as quadratics, elementary physics and Latin equivalent to one year's study in the high school. A presentation of a college degree in letters or science, a diploma or certificate of graduation from an academy or high school, or a certificate showing that the candidate has passed the entrance examination to an accredited college or scientific school, will also enable the applicant to enter a college.

The members present at the meeting were Louis Adelsberger, of Waterloo, President; C. B. Johnson, of Champaign; Florence W. Hunt, of Chicago; P. H. Wessell, of Moline. M. Meyerovitz, of Chicago; Z. D. French, of Lawrenceville; Julius Kohl, of Belleville, and J. A. Egan, Secretary.

Sued.—A wet-nurse employed by St. Ann's Orphan Asylum, of Missouri, has brought suit against the institution for \$100,000 damages, her charge being that she was given a syphilitic child to nurse, whereby she contracted the disease.

New Society.—The Spirit (Iowa) Lake Medical Association has been formed. It has a membership of thirteen. The officers are: President, E. L. Brownell; Vice-President, E. E. Munger; Secretary and Treasurer, C. S. Shultz. The following are the members: Drs. A. E. Burdick and R. C. Mollison, of Graettinger; A. E. Rector and C. S. Shultz, Lake Park; R. J. Hamilton and R. G. Hamilton, Ocheyedon; E. E. Munger, Spencer; C. B. Adams, Estherville; C. M. Coldren and Q. C. Fuller, Milford, and J. B. Stair, C. B. Fountain and E. L. Brownell, Spirit Lake. Spirit Lake will be the permanent place of meeting. Next meeting in December.

The Mississippi Valley Medical Association.—Arrangements for the coming meeting of the Mississippi Valley Medical Association at Louisville, Ky., October 5-8, 1897, are nearly completed. The different railroads have granted a round trip rate of one and one-third fare on the certificate plan. The sessions will be held at the Liederkrantz Hall. Our readers will do well to reserve their room at the Galt House. Many valuable papers have been announced, and the indications are that the meeting will be a most interesting and successful one.

Elected.—Dr. Walter B. Dorsett, of this city, has been elected Second Vice-President of the American Association of Obstetricians and Gynecologists.

Ho For Louisville!—Take the B. & O. S.-W. Railway. Good tracks, clean cars and rapid transit. A large delegation of St. Louis doctors will take this route to the Mississippi Valley Medical Association, October 5-8, 1897.

Died.—Dr. H. C. Bulis, of Decorah, Iowa, died September 7th. He was for many years one of the Regents of the Iowa State University.

College of Physicians and Surgeons of Keokuk.—The fifty-seventh session was opened on September 15th. A large audience was present to attend the formal exercises. Professors Hughes, Hillis, Barr, Dorsey, Radasch, Cowen, A. B. Hughes and Sisson were present.

Professor Hillis, president of the faculty, announced the opening of the session and expressed his gratification and that of his associates at the large attendance in spite of the heat. He also spoke of the satisfaction of the faculty at the large enrollment at the beginning of this, the fifty-seventh year of the college, and said that the class would grow in the next few weeks as it always does. He announced the lectures for to-day and warned the students that they have six months of hard study before them.

Professor Sisson was then introduced as the speaker of the evening, and his subject was announced as "The Medical Profession." His introduction was a beautiful word-picture of sunrise in the Alps. He said that words failed him in this description as they failed him in his effort to depict the glories and possibilities of the profession chosen by the young men and women before him. He rapidly sketched the traditions and history of the profession from the time of Homer, speaking of the great men who had honored it. All nations were represented—Greek, Roman, Moslem, Italian, French, German and English, all have done their share.

Death of Dr. Finley.—Dr. E. L. Finley, died at Streator, Ill., on September 3d, of cerebro-spinal meningitis, in the thirty-fifth year of his age.

Important Meeting.—Our readers are invited with their friends to attend the ninth annual meeting of the Tri-State Medical Society of Alabama, Georgia and Tennessee, to be held in the Auditorium of the Tulane Hotel, corner Church and Spruce streets, Nashville, Tenn., Tuesday, Wednesday and Thursday, October 12th, 13th and 14th, 1897.

If you desire to read a paper, report a case, or exhibit a specimen, notify the secretary. Reduced railroad rates to the Tennessee Centennial. FRANK TRESTER SMITH, M. D., Secretary, Chattanooga, Tenn.; W. F. WESTMORELAND, M. D., President, Atlanta, Ga.; W. D. HAGGARD, JR., M. D., Chairman Committee of Arrangements, Nashville, Tenn.

Health in St. Louis.—As compared with other large cities, St. Louis makes an excellent showing in death rates from all causes. The death rate in St. Louis in 1896 was 15 per 1000; New York showed 19, Boston 21, Philadelphia 18 and New Orleans 24. Fifteen deaths to the 1000 is a very good record for any great city. It means that the city is naturally situated in a healthful spot, and that its sanitary conditions are well looked after.

CORRESPONDENCE.

THE ORIGIN OF FIFTY-CENT HOSPITALS IN ST. LOUIS.

EDITOR JOURNAL:—In looking over the columns of the *American Journal of Surgery and Gynecology* of June issue, I read with pleasure the discussion of the vital question which presents itself to the medical profession of this great city, and I thoroughly agree with you in the stand you take in the matter. The lying and deceit practiced by the men who assume to be the leaders in the profession in our city is simply beyond the power of pen to describe. That I am the instigator of the scheme which has caused the springing into existence of what, to-day, is probably the leading Hospital Association of the city I make no attempt to deny; neither do I go behind a cloak to escape the censure which rightly belongs to such enterprises, for, as all well-meaning physicians know, they are the beginning of the death-knell to the most honorable profession the world has known. But stop! Let us look into the reasons which have caused such institutions to spring into existence. What are they, and why do they exist? In the first place, I will answer the question as to why the Merchants' and Manufacturers' Hospital sprang into existence. It was for the reason that there was not a single hospital in the city of St. Louis to which one could send a patient and not fear that the patient would be stolen directly away, or else if not successful in appropriating to their own use what rightfully belonged to another, that the surgical skill of the party who sent the case to the hospital would be criticised in the presence of the patient thus: "Yes, you are getting along nicely, considering whom

you had to operate; but you would have done much better if you had had Dr. So-and-So, whose experience has been much greater than your physician, and who is Professor of Surgery in such and such a school." Such treatment as this I had to put up with for years and said nothing; but at last, circumstances forced me to act, as I found that unless I had a place where I could send my patients and not have them interfered with, I might just as well quit the profession. Why, time and time again have I had the honorable or should-have-been-honest Professor cut in half the fee which I had asked and reduce the cost of hospital accommodation and thus secure the money from my very grasp. Furthermore, these self-styled leaders of the profession have invaded my territory and contracted at so much per hundred men, to attend to the maimed and ill. Thus, from year to year I have seen my business diminish, and between the Professors and their college clinics, and the free dispensaries, run either directly by the schools or their hirelings, have I been forced to act. I have acted, and as a result have virtually closed three out of four of the free dispensaries; have deprived the clinics of the medical schools of several thousand patients; and have to day a place where I can take my patients without fear of interference.

The St. Louis Medical Society, I am pleased to state, has a few good men in it, who rarely attend its meetings. When I wish to join a pure "Mutual Admiration Club," I will hand in my application and give the great "I ams" an opportunity to reject me. Until such time as I can see how and when the profession can and will be cleansed of its wolves and sharks who parade in the clothing of the lamb, I shall continue to fight in the lines laid out; but should the time ever come when the St. Louis profession will be controlled by thoroughly honorable men, then will I most willingly join hands and try to correct the existing evils. Until then, let the war go on, and let it be a question of the survival of the fittest. I shall, at no time, hide under a cloak of religion, nor shall I move a part of my hospital across the street and shout: "Hello! I have severed my connection with the 50-cent hospital."

Respectfully yours,

H. E. THOMPSON, M. D.,

St. Louis, Mo.

Sec. and Medical Director M. & M. Hospital.

THE COUNTRY DOCTORS ARE WITH US.

SHELL ROCK, IA., September 11, 1897.

TRI-STATE MEDICAL JOURNAL. St. Louis, Mo.

Dear Sir:—Enclosed find a one dollar bill to apply upon my subscription. Am pleased with your editorials in taking up the "medical college craze." The entire profession should unite and try to stamp out this multiplication of so-called colleges. Institutions organized, not for fitting students for successful work, but solely to advertise a few self-constituted professors who, I am sorry to say, are themselves many times sorely in need of clinical training, thereby overcrowding the land with a multitude of experimenters. Keep the ball rolling.

Yours respectfully,

W. H. SMITH, A. B., M. D.

NEW SUBSCRIBERS.

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER has something of which few medical journals can boast, viz.: a genuine subscription list. We do not send out sample copies; but by judicious advertising and by solicitation we steadily grow. Advertisers appreciate a progressive and growing journal. The names given below have been received in the last eighteen days. All but twelve of these persons paid their subscription in advance.

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ABSTRACTS.

Ferratin in Tuberculosis.—Dr. W. T. Parker, in a paper on "Normal Horse Blood Serum in the Treatment of Tuberculosis," read before the Section of State Medicine at the June, 1897, meeting of the American Medical Association, speaking of the treatment of tuberculosis, says:

"In those cases where tuberculosis has been successfully treated by therapeutic methods, iron has been the most valuable remedy. As every one knows, the preparations of iron are very numerous; some of them positively harmful; others inert and useless, while a few are capable of being readily assimilated. Of this kind, ferratin, is one of the new remedies recommended by the Committee of Revision for adoption into the new fifth edition of the Russian Pharmacopeia (*Chemiker Zeitung*, 31, 1897).

"This is an organic iron compound of albumen and tartrate of iron, forming a definite albumenic acid; it contains 7 per cent. of iron, is readily absorbable, does not constipate, and has no untoward effects. On the testimony of its discoverer and others, it is identical with the natural ferruginous element of food, absorbed in the system and stored in the liver and other organs as a reserve iron for blood formation (*Journal American Medical Association*). Lately this preparation has attracted considerable attention, not only in Europe but in this country; so much so that its future success would seem assured."

A Holy War.—The *American Journal of Surgery and Gynecology* and the TRI-STATE MEDICAL JOURNAL, of St. Louis, Mo., have opened up their batteries on the hospital and dispensary abuse in that city. They publish a report of a committee appointed by the St. Louis Medical Society for the purpose of investigating the methods of the cheap hospitals and free dispensaries of the city.

The report is anything but complimentary to the institutions, and puts the professors connected with them in a very inconsistent attitude.

There is no doubt in the mind of any physician but that the free dispensary, as conducted at present, not only in St. Louis, but in every large city in the country, is absolutely disgraceful and demoralizing, not only to the physicians connected with the business, but to the majority of the patrons.

The original idea of the free dispensary was a noble and charitable one, but as most of them are conducted to-day they have become the opposite.

When any one receives anything in the name of charity for which he is able to pay, he thereby secures that something under false pretense, and by the act becomes a criminal in the eyes of the laws of our land.

Could anything be more demoralizing than to open up institutions in the name of charity, and then run them in the interest of self-styled "professors," who run a medical college solely for the purpose of making money, and advertising themselves in a way that would not be tolerated by any decent medical society in the country under any other circumstances?

We would not have it understood that we are opposed to charity, for no set of men do more real charitable work than the medical profession; but when the country doctor goes in the city and spends an hour in one of the modern free dispensaries, and sees the well-dressed, prosperous looking patients who appear for treatment; displaying more evidence of ability to pay than he finds in his whole clientage; and then as he passes from the place, his attention is attracted to a large placard, two and one-half by three and one-half feet in size, upon which he reads the following very startling announcement:

ALL PATIENTS
DESIRING TO BE TREATED
AT ONCE,
CAN BE ACCOMMODATED BY SECURING
SPECIAL TICKETS
FROM
DR. SAY.
PRICE, 25 CENTS A WEEK.

Charity, indeed! Charity for twenty-five cents per week! Twenty-five cents a week means much to many poor people in the large cities, but it must be forthcoming or you must give way and bear your suffering until those who are able to pay their way are provided for. If this is charity, may we be delivered from such damnation.

But how does it affect the doctors of the country and small towns? In the first place, it drives thousands of bright, active young doctors from the cities who become our competitors and divide up our business, who would remain in the large cities were conditions otherwise.

Then, many of our patients have friends and relatives in the cities who induce them to go there for treatment, and especially for surgical operations that could be done as well by us; and the traveling expenses to the city and return, would in many cases be a sufficient remuneration to us for the operation.

But the friends write: "Come to the city. Your case will be treated

here by the great and eminent Dr. Blowhard, professor in the Bombast Medical College, and it will not cost you a cent!" But at first our moral patient objects to posing as an object of charity, and securing free treatment. But her mind is soon disabused of that ancient and effete idea, when the friend writes that it is not necessary to feel that way, for we and all of our set go to the dispensary—or fifty cent hospital—in fact, it is considered quite the thing; and some morning when you call to see your patient you are told that she has gone to St. Louis to be treated in the hospital—and you are out fifty dollars, more or less.

The demoralizing effect of the abuse reaches every member of the profession. What other effect can it have on the medical student who today is told by the professor in his college that advertising by a member of the noble profession is degrading and beneath the dignity of a medical man; picks up the leading daily paper at breakfast the next morning and reads in glaring head lines: "HIS BACK-BONE TIED WITH WIRE!" or this: "RARE SURGICAL OPERATION!" or, "HER MIND RESTORED!" or the following poetical announcement: "AT RYBDELL'S HEART DOCTOR — TOOK A SHOT!" Reading down the column he finds that the hero of this wonderful achievement is the noble old Esculapius who had informed him the day before that advertising was so degrading.

Every one of these headlines and many more equally as startling have appeared in the daily papers of St. Louis. And who has done these wonderful operations? Dr. Charlatan, or Dr. Quack? No; in almost every instance it is a professor in some one of the medical colleges of that—as regards the production of medical colleges—very prolific city.

A most deplorable state of affairs, to say the least! Drs. Ball and Lanphear deserve credit for the noble effort they are making, and we hope other journals will join in denouncing the disgraceful methods of these men and their institutions. Whether or not any material reform along this line is possible remains to be seen.—*Oklahoma Medical Journal*.

Sentiment versus Syphilis in India.—As might have been expected, recent occurrences have roused the ire and indignation of the sentimentalists who formerly secured the repeal of the English Contagious Diseases Acts. Last week a meeting of the faction was held in London under the presidency of Mrs. Josephine Butler. The occasion was the annual foregathering of the society that labors under the pretentious title of "The Ladies' National Association for the Abolition of the Government Regulation of Vice." Among those present who seemed to think sentiment more desirable than syphilis or than State regulation, were Sir James Stansfeld, Mr. James Stuart, M. P., Mr. and Mrs. H. J. Wilson, Mrs. Solly (Cape Colony), Dr. Annie McCall, and Miss Florence Baggan. The views of the meeting may be gathered from the assertion of Sir James Stansfeld that the ladies' petition of approval recently presented to Government was not understood by the signatories, but was couched in the words of the doctors and soldiers who for twenty-five years past had worked to make vice safer. Well, Sir James has striven in the other direction for a similar period, and the results have been to make loathsome disease more deadly and rampant. He seems to think that he can send a body of vigorous young men

into a tropical country and expect them to remain continent under strict disciplinary measures. Alas! poor human nature, one might as well try to satisfy a hungry man by taking him to church. Fortunately, the world nowadays is beginning to look at these matters from a common-sense and practical point of view, and the party led by Sir James is not likely to wreck either Bills or Acts in the future.—*Medical Press and Circular*.

If **Cod-Liver Oil** has been able to maintain its position as a remedial agent from a time "beyond which the memory of man runneth not to the contrary," its present popularity certainly has not resulted from any lack of sharp and sustained controversy. While the literature commending its utility in a wide variety of disorders is very copious, there has likewise been an abundance of articles, papers, and discussions, which contended that cod-liver oil was merely a therapeutic fetich; that it possessed no virtue that did not likewise reside in all forms of food fat; that it was no more readily assimilable than good butter; that, indeed, it was a positive bane to the patient in its loathsome taste, its disturbance of digestion, its provocation of biliousness, etc.

In my opinion these dissenting views constitute a most erroneous and deplorable heresy. Quite apart from the colossal volume of clinical testimony which bears witness to the real, genuine and positive utility of cod-liver oil in all wasting diseases, my own experience in practice sustains the view that cod-liver oil is an agent of incontestable value when intelligently, perseveringly administered.

The best and purest oil should be obtained, since the inferior oils are offensive in odor and taste. I thoroughly approve of a good emulsion when the microscope shows that it contains the *entire oil* in finely divided globules, and when I am satisfied that the percentage of oil claimed by the maker is present in the emulsion. Emulsification, moreover, forms a necessary step in the digestion of the fat, and the ready-made emulsion reduces the burden of labor devolving on the enfeebled digestive organs. The product which has given entire satisfaction in my practice, and to which I pin my confidence, is the egg emulsion of cod-liver oil (P. D. & Co.). This product does not deteriorate, is most satisfactory in taste and flavor, and contains, by volume, full 40 per cent. of the entire oil. The absence of gum arabic, Irish moss, or the other emulsifying agents commonly used, is assuredly not the least of its advantages.

I have no faith in the so-called wines of cod-liver oil, containing, not the whole oil, but an extract of the alleged alkaloids. As urged by Prof. Winter, cod-liver oil is a most complex body. Its beneficial properties reside in the aggregate of its constituent elements, and it is a piece of cruel jugglery to proffer a patient a part in lieu of the whole. The deception pointed out by Professor Hare—the entire absence of cod-liver oil from some of the advertised emulsions—merits the severest reprobation of the profession. There should be a fixed standard for emulsions, and the physician should have some positive assurance that the percentage asserted on the label is actually present in the contents of the bottle.—DR. FRANK WEBSTER JAY, in the *Journal of the American Medical Association*, April 3, 1897.

British Surgery in America.—The second course of Lane Medical Lectures will be given by Mr. Christopher Heath, late President of the Royal College of Surgeons, England, in September next, beginning on the 18th inst. at the Cooper Medical College, San Francisco. There will be two lectures daily, one in the morning, and the other in the evening. The following is a list of the subjects:—Two lectures on Congenital Malformations; two on Diseases of the Rectum; two on Diseases of the Jaws; one on Diseases of the Tongue; one on Diseases of the Joints; one on Aneurism. The concluding lecture, says the *Occidental Medical Times*, will be on "A Century of Surgery." We congratulate Mr. Heath upon the honor which has been conferred upon him of having been invited to deliver these lectures. That a British surgeon should have been asked to fill the post of Lane Lecturer is a compliment to British surgery certainly worthy of note. —*Medical Press and Circular.*

Brain Weight as a Gauge of Intellect.—Sir William Turner has been riding an old hobby in a new country, thus taking a leaf out of the book of the clergyman on holiday who takes with him an old sermon for any strange pulpit he may chance to light on. Sir William has all his life been interested in brains, and for many years his own brain has crystallized certain ideas which appear logical and sound at first sight, but are not so on deeper investigation. His opinion is that the higher we rise in the scale of humanity the more perfect becomes the control of the animal instinct, and the more do the emotions, passions, and appetites become subordinated to the self-conscious principles which regulate our judgments and beliefs. This is all very well as a pious opinion, and there is a great deal of truth in it, but it is not the whole truth. Higher civilization does not necessarily mean greater inhibition, for it implies in many instances greater self-indulgence. This, by the way, however, we come now to the more direct question of brains. Sir William presents us with an array of figures. We are told that the average weight of a European's brain is from 49 to 50 ounces. These are male weights—and the average weight of the brain for certain picked men of ability and intellectual distinction was from 55 to 60 ounces. He is careful to add that to have a heavy brain is not necessarily to have intellectual eminence. Then, why draw deductions at all? Why lead us to infer that because there is less difference in the capacity of crania of men and women of savage races than in those of civilized countries, the women of the latter are relatively more intellectual than those of the former. At this time of day we do not need the authority of Sir William Turner to guide, or rather misguide, us on this question. To speak of the weight of the brains as a guide is unscientific—a mere rule of thumb—when it is remembered that intellect is but a part of brain function, and some will not even admit so much, that brain having physiological relations with every structure of the body must have corresponding physical proportions. Not only so, but there are intrinsic differences in axis cylinders, neuroglia structure, the nervous ramifications, and the nerve cells which do not in proportion to bulk or multitude signify the same thing, for localities of distribution have different physiological meanings, and quantity may have a negative or positive meaning according to the structure in question. We have just taken the trouble to go over the brain weights of

fifty lunatics taken without selection from post-mortem records. Five out of thirty-one males give weights ranging from 51 to 56 ounces, the average of all being $48\frac{1}{4}$. Of the females, twenty-two in number, we get an average of $44\frac{1}{4}$, and of these three exceeded 50 ounces—viz., $50\frac{1}{2}$, $51\frac{1}{4}$, $52\frac{1}{4}$. It is, moreover, a well-known fact that epileptics have usually large brains. It is, however, no use trying to slay a dead dog, though Sir William Turner has tried to revive him. The facts and the common sense of science speak for themselves.—*Medical Press and Circular*.

On Certain Apparently Organic Tumors of the Orbit Which Disappear Under Medicinal Treatment.—Snell (*The Lancet*) says: "I have for a long time been familiar with the clinical fact that internal medicine can, in certain cases, bring about the disappearance of orbital tumors. This is true, moreover, of tumors which exhibit features rendering differentiation from those of a malignant or certainly organic nature difficult, and but for the effects of treatment the distinction would, perhaps, be impossible without an examination of their minute structure. Just now, I am thinking particularly of orbital growth so occurring at about the middle period of life, when those of a malignant nature would be prone to arise.

"Panas, of Paris, at the annual meeting in London of the British Medical Association in 1885, brought forth a very valuable and instructive paper dealing with the pseudo malignant tumors of the orbit. He expressed the opinion that because dispersion of these growths followed the administration of iodide of potassium it was a mistake to regard syphilis as the only cause, and he believed that a number of neoplasms thought to be lymphomas, sarcomas, or syphilomas ought to be attributed to the dyscrasia produced by some toxin. He spoke of a class of infectious tumors, the syphilitic being an example, but not the only one. We are, of course, all familiar with the frequent impossibility of getting a specific history even in cases which admit of little doubt of syphilitic taint. * * * But Panas' observations are, nevertheless, of interest, as he recounts instances which have undergone apparent cure with treatment by arsenic and other remedies which can hardly be regarded as antisiphilitic."

Snell then gives the histories of three cases in middle-aged persons: "The cases mentioned bear a very close clinical resemblance to tumors regarded as sarcomatous and in which the diagnosis has been confirmed by the microscope after the growth has been removed. There was the same evidence to the touch of a somewhat hard, elastic tumor, not fluctuating or pulsating, and somewhat nodular on the surface, as an organic tumor would present. Treatment proved that they could be dispersed without operation, and therefore it appears to me that the lesson to learn is one that Panas enforced in the paper to which I have already directed attention, viz., that before resorting to surgical measures for orbital tumors, the effects of internal treatment should be tried. It is not necessary that iodide of potassium with or without mercurial inunction be employed, for Panas mentions the benefit derived from arsenic and other remedies. Panas also suggests that serum, according to the nature of the infection which has been at work, should be used.

"The simplest way of accounting for the presence of such tumors as I have referred to is, of course, to presume that they are syphilomas and

very naturally to discount the absence of specific histories. If we are to believe that, as a consequence of dispersion following the administration of the iodide, the nature of the tumor has been proved, nothing more, of course, can be said. I confess, however, that my feeling is that such tumors as have been referred to in this short communication are not necessarily syphilitic, and that the observations of Panas as to unilateral or bilateral orbital growths afford strong support to such a contention."—*Memphis Med. Monthly*.

Tonsillitis.—Dr. F. W. Fabricius, M. D., of New York, N. Y., says (*Virginia Medical Semi-Monthly*): Simple tonsillitis is a harmless affection, rarely calling for active interference. The follicular variety, however, if neglected, may place the patient in a critical condition. Repeated attacks ultimately result in hypertrophy of the lymphoid elements in the pharynx.

Tonsillitis, *per se*, is not a self-limited disease; therapeutic measures, therefore, if applied early, are highly beneficial in checking the disease before reaching the chronic stage.

One of the most efficient remedies at our command is the salicylate of sodium. In the acute variety, especially during an epidemic, this drug seems to exert an almost specific inhibitory influence. The salicylates reduce temperature, lessen pain, arrest fermentation, and check putrefaction—all prominent factors in acute throat affections. On an empty stomach they irritate and induce nausea; they should, therefore, be suspended in milk or dissolved in mineral waters and administered soon after eating. In capsule or pill form the irritating qualities of the drug delay prompt absorption. The most suitable preparation is the salicylate of sodium, alternating, if necessary, with the oil of wintergreen.

In all cases, unless directly contra-indicated, an active purgative proves of service. Calomel is a universal favorite, and deservedly so. One-quarter of a grain, in the form of tablet triturate, every ten minutes, till four or five grains are consumed, will, by the aid of a Seidlitz powder, insure free action in the course of two to three hours.

Satisfactory results can only be obtained by prompt exhibition of the remedial agent. In ordinary tonsillitis, sodii salicylatis gr. xv. sodii bicarbonitis gr. xx. every three hours, will generally effect a cure within twenty-four to thirty-six hours.

In the severer types, the treatment must be more energetic and the intervals between doses lessened; after five or six doses, the quantity may be reduced one-half without changing the time; we must be guided largely by the tolerance of the individual, although the drug is well borne in the acute stage, especially if of the parenchymatous variety. The tincture of the chloride of iron exerts a favorable influence on the progress of the disease, and is given in five minim doses, well diluted, every two or three hours, alternating so as to avoid a combination with the salicylates, which results in an unsightly mixture.

If early in the disease the temperature runs high and the skin is dry and hot, half minim doses of tincture aconite root every half hour for three or four hours, relieve the cutaneous irritability and allay the burning pain in the throat.

Gargles are of little avail, as they fail to reach the seat of the inflam-

mation; a mouth wash, consisting of boric acid or alum flavored with peppermint, serves to cleanse the buccal cavity, which, with strict attention to the cleanliness of the teeth, is vastly important in all throat affections. If the excreted fluid is abundant, the pharynx may be mopped out at regular intervals with cotton soaked in peroxide or other antiseptic lotions.

Convalescence is generally established on the third day, and the salicylates can then be omitted. The iron should be continued, if the patient is in poor physical state.

When suppuration threatens, early incision must be advised; but only in exceptional cases will surgical interference be necessary. Out of one hundred and ninety-eight cases subjected to the above treatment in hospital and other practice, but four terminated in tonsillar abscess, two of which belonged to the chronic parenchymatous variety.

In greatly enlarged tonsils, multiple scarification with a bistoury brings considerable relief to pain, and lessens the discomfort during deglutition.

In chronic cases subject to acute exacerbations, the following combination, applied directly to the inflamed area, has yielded gratifying results:

℞	Tinct. aconit. rad.....	ʒ ss
	Tinct. bellad.....	ʒ j
	Tinct. ferri chlor.....	ʒ ij
	Tinct. iod. co.....	ʒ iiss
	Glycerin.....	q. s. ʒ j

M. S.—Topical. Apply with brush.

Chronic tonsillar hypertrophy sometimes improves under iodide of potassium; tonsillectomy, however, is preferable; it is performed when the inflammatory process is least active, to lessen the risks of free hemorrhage and septic absorption.

The after-treatment should be directed mainly towards prophylaxis, interdicting heavy smoking and the use of raw liquors.

Tic Douloureux.—In the treatment of neuralgia of the fifth nerve, the salicylates have yielded very satisfactory results, more so than any other agent; out of seventy-two cases under observation, not one proved disappointing. The following will serve as an illustration:

A confrère was subject to monthly attacks of severe trigeminal neuralgia, for which he had three healthy molars extracted in the hope of obtaining relief. The pain later on increased to such intensity that he was compelled to take morphine, sometimes one-half a grain twice during an attack, which generally lasted four days.

At the onset of the next attack he received gr. xv. of sodium salicylate combined with gr. x. of sodium bicarbonate, continuing with gr. v. each every fifteen minutes for five doses, after two hours repeating the first full dose. In the course of two hours the pain gradually abated and left him free for four and a half weeks, when it recurred with undiminished severity. The same plan of treatment was resumed with similar success. This time the paroxysm did not return for two and a half months, when it was easily controlled by one full dose of salicylate of sodium. Since that time the attacks recur only once or twice a year. The origin of the neuralgia in this case was not clear; rheumatic history could not be obtained.

PUBLISHER'S DESK.

A TALK WITH ADVERTISERS.

The best proof of an honest circulation is the publication of post-office receipts regularly. It has too often happened that in the transactions between advertiser and publisher business principles have been ignored. While in all other transactions Shylock demands his pound of flesh, in the advertising business imagination runs riot and plays havoc with good judgment. It enables the advertising solicitor to see his circulation as he would have others see it, and it seduces the advertiser into believing the fairy tales told him by the solicitor. Advertisers do not seem to be aware that the "cold facts" of the advertising business are accessible, if they only demand to know them.

The circulation liars are abroad in the land seeking whom they may devour. They infest every class of journalism and are by no means rarely found in medical journalism. The advertiser who does not know the ins and outs of the publishing business falls an easy prey to the wolves. The stronghold of the circulation liar is the fact that his statements are rarely investigated. In the absence of an investigation he can claim almost any circulation and be safe. He can raise his advertising rates in proportion and acquire money rapidly. The claim of the circulation liar gives the advertiser a false idea of what the circulation of a medical journal should be. He compares the modest figures of the honest journal with the attractive figures of the circulation liar, and often the honest journal is looked upon with distrust while the fakir sheet is greedily accepted.

Sworn statements are often resorted to by the circulation liar. He presents an elaborate and artistically neat document, giving affidavits from the printer, publisher, binder and devil, showing an immense circulation, when in truth, he may have issued only a small number of copies. It is a notorious fact that such "sworn statements" can be had without difficulty. They are valueless, except that they place the fakir upon record and may be used against him if any one desires to institute criminal proceedings. Some medical publishers do not seem to know that this misrepresentation is an indictable offense, because it is obtaining money under false pretenses. It is strange that advertisers should look upon this form of robbery with so much complacency without even asking for proof of circulation. With so simple a method of proving circulation at hand, it is possible for every advertiser to get facts before he invests his money.

The advertiser would test a journal's circulation. How does he proceed? Does he ask to inspect the publisher's subscription books? Does he visit the printing office and watch the printing of the journal, or ask for Uncle Sam's post-office receipts? Oh, no! He tests the circula-

tion by giving the journal a trial advertisement, and if he gets no immediate returns he condemns the journal as valueless, and brands it as a dishonest journal. This is not a fair test. A good journal may bring no visible results at first, but may be about to bear fruit when the trial advertisement is cut off. A good circulation in the right field will bring results sooner or later, and a journal with no real circulation will only cause a great waste of advertising money. Therefore, the advertiser should know before he invests his money just what and where the circulation of the journal is.

When the advertiser finds that he is wasting money he cuts down space wherever he can. How can he do this wisely? Retrenchment in no longer paying for what he does not get is infinitely better than a horizontal slashing of advertising space in an indiscriminate manner. He must find out where the padded circulation is and stop paying for it. He must not confuse the results from a good medium with baseless claims of another, which is so often done. He will be continually at sea until he has seen proof of the actual circulation of each journal.

The best proof of circulation—we had almost said the only proof—is the exhibition of post-office receipts from issue to issue. Nobody can fool Uncle Sam, and his receipts are now accepted by the shrewdest manufacturing houses as the only proof of a medical journal's circulation.

HONEST MEDICAL JOURNALISM.

The chief revenue of a medical journal is derived from advertisements. Advertisers generally wish to know that they get what they order and pay for. In this they are only human. If a doctor orders a meal at a restaurant or hotel, he expects to have the order filled correctly. So with the matter of advertising. The advertiser wants and is entitled to receive that which the medical publisher promises him.

Unfortunately for legitimate journalism there are not a few publishers of medical journals who claim immense circulations for their journals and sell space to advertisers upon the basis of a condition which does not exist. So frequently has it been found that such journals often print only one-tenth as many copies as they claim to have subscribers, that if an honest publisher states his circulation correctly, he often is not believed.

The only basis on which to do business with medical journals is for the advertiser to demand proof of the exact circulation. Such proof can be easily furnished by any publisher who will exhibit his post-office receipts for the number of pounds of each issue of his publication as it is mailed. Then, by a simple mathematical calculation, any advertiser can tell the exact circulation, and know whether or not he gets what he pays for. For the advertiser to demand such proof before paying his bills, according to our way of thinking, is neither a hardship nor a discourtesy to the medical publisher. If the publisher buys 1,000 reams of paper he has it counted before he pays for it. Why should not the advertiser be granted the same right?

Now, having arrived at these conclusions, THE TRI-STATE MEDICAL JOURNAL will begin the new year prepared to prove to any interested

party, be he subscriber, advertiser, friend or foe, that we actually print and mail over five thousand (5,000) copies each month. In the February number we will print a *fac-simile* reproduction of our post-office receipts for January, and this plan will be followed throughout the year. Our *bona fide* circulation of 5,000 per month will more than equal the 10,000 to 20,000 *claimed* by Munchausen sheets. The circulation liars must take a back seat, for we have cleared the decks for action.

Worth Knowing.—The following strong tribute to the merits of Imperial Granum is from one of the most eminent physicians of Philadelphia: "I have had faithful trials made of Imperial Granum, and can announce it to the profession as a good, reliable food as a substitute for mother's milk in little babies afflicted with any digestive derangement, but especially in enteritis, or what is commonly known as summer complaint." Physicians can obtain samples of this most valuable food free, charges prepaid, on application to John Carle & Sons, 153 Water street, New York City.

Sanmetto in Gonorrhœal Inflammation and Emaciation.—I have used Sametto in a number of cases of gonorrhœal inflammation and find it all that could be desired. I also consider it as a good constitutional treatment where there is an emaciated condition of the system superinduced by venereal disease.

G. B. FAYNE, M. D.

Earlington, Ky.

Are You in Pain?—You will probably ask this question more frequently than any other. Nothing appeals to one more strongly: To be able to relieve pain, whether it be a slight nervous headache or the most excruciating suffering from a severe neuralgia, brings the height of pleasure to both patient and attendant. The ideal remedy must not only do its work, but it must also do it quickly. Touching this point is an article in the *Boston Medical and Surgical Reporter*, By Hugo Engel, A. M., M. D. The author says: "Antikamnia has become a favorite with many members of the profession. It is very reliable in all kinds of pain, and as quickly acting as a hypodermic injection of morphia. It is used only internally. To stop pain one five-grain tablet (crushed) is administered at once; ten minutes later the same dose is repeated, and if necessary, a third dose given ten minutes after the second. In 90 per cent. of all cases it immediately stops the pain."

Conservatism in the Treatment of Diseases of the Pelvic Organs in Women.—In the March issue of the *University Medical Magazine*, Drs. S. Weir Mitchell, Wharton Sinkler, Charles K. Mills and others, in discussing the relation of nervous disorders in women to pelvic diseases said: "We have never seen a case in which ablation of the ovaries and termination of menstruation cured an epilepsy, and in all our life have met with only four reflex epilepsies, none of which were from uterine, ovarian or tubal diseases; and we are inclined to think that some at least of the cases classed as epilepsies of ovarian origin, are in reality excessively violent hysterical convulsions; and we conclude that insanity is aggravated by the menstrual epoch, whether normal or not, but that it is very rarely caused by that alone. A great deal of uterine and ovarian disease should escape the knife by the use of patient medical treatment—no grave surgery of the

pelvis should be allowed without medical consultation," and by the conservative administration of Dioviburnia, a uterine tonic and alterative, nervine and antispasmodic. In these opinions they voiced the sentiments of the great army of specialists and general practitioners.

Backache.—It is with pleasure that I give you my experience with Sanmetto: "Mr. B., aged forty-nine years, was a sufferer for years from backache, caused from inflamed and overworked kidneys. The pain was so great at times that an opiate had to be given to relieve it. I put Mr. B. on Sanmetto, teaspoonful three times a day. He has never complained of his back since. This has been three months ago."

Gold Hill, Ala.

J. HARVEY BLEDSOE, M. D.

Treatment of Anemia.—The treatment of anemia gives the practitioner of medicine much trouble. We have prescribed stomachics, iron in pill or liquid form, foods, etc., and still the results are unsatisfactory. Iron is indicated, no doubt, but causes, on the other hand, gastric disturbances, constipation, etc. It is this latter affection that is apt to lead to disastrous results. Constipation in anemia ought to put the physician on his guard—it is absolutely dangerous, be it even for this reason that this function being interfered with, auto-infection takes place, against which the already weakened blood cannot resist. Digestive disturbances prevent the patient from taking proper food—making nutrition impossible; one of the key-notes in the treatment of anemia, a preparation that will not constipate nor interfere with digestion is ideal, and such we have in Henry's Three Chlorides, which contains not only proto-chloride of iron, but mercury, arsenic and calisaya alkaloids, every ingredient itself being desirable in the treatment of anemia.

Neurosine.—Neurosine contains no morphine, chloral or opium, although it is the most powerful neurotic attainable. The standard remedy for the treatment of all forms of nervous disturbances—anodyne and hypnotic. The most efficient and trustworthy agent for the relief of hysteria, epilepsy, neurasthenia, mania, chorea, uterine congestion, neuralgia, migraine, delirium tremens, asthma, spermatorrhœa and all convulsive and reflex neuroses. The remedy par excellence in delirium and restlessness of fevers.

Worth Remembering.—MESSRS. JOHN CARLE & SONS, New York City.
Gentlemen:—It affords me pleasure to inform you of my high estimation of the value of Imperial Granum in a recent case of obstinate vomiting of pregnancy. For many days at a time my patient could retain practically nothing in the way of nourishment until the Imperial Granum was tried, when the stomach immediately became more tolerant and nutrition was rapidly regained—and at this writing, four weeks from the time she began its use, she is still relying almost exclusively on it for nourishment. It is safe for me to say that in the future I shall depend on the Imperial Granum when its use is indicated, and with best wishes for your success, I am,

Yours very truly, ——— M. D.

Physicians can obtain samples of this most valuable prepared food free, charges prepaid, on application to John Carle & Sons, 153 Water street, New York City.

Dr. Paul Clifton, of Kansas City, reports a case of indolent ulcer, and gives treatment: I first cleansed the wound with peroxide of hydrogen, then with a sharp curette thoroughly curetted the entire surface, carefully covering the curetted surface with absorbent cotton, dampened with ten per cent. solution of chloro-phenique, then with a pair of pressure forceps lifted up the overlapping margin, and with a scalpel removed the reddened and angry-looking tissue well back of the line of demarcation, and into healthy cuticle. The wound was then thoroughly irrigated with hot water, containing a liberal quantity of chloro-phenique; after all oozing ceased, the surface was thoroughly dusted with campho-phenique powder, a silk rubber strip laid over and a roller bandage applied. To the surprise of all, when the dressing was removed on the third day, the entire surface showed unmistakable evidences of healthy granulation; the same form of dressing was again applied and the patient told to return in three days; but at that time, as there was no pain nor any of the characteristic odor of the old ulcer, we decided not to disturb the dressing. He was sleeping well and had a good appetite, an experience he had not enjoyed for several years. Within the next day or two he became anxious to return to his home in Ohio, saying that if the limb would remain as it was then he could work whether it healed or not, so we concluded to give it another dressing and let him go. This was on the eleventh day, and our surprise can be better imagined than described when upon removing the dressings the entire surface of what had been the old ulcer was seen to be thoroughly and completely covered with healthy granulations, presenting that pinkish hue that denoted they had come to stay.

Since that time I have personally treated in the same manner and with the same remedies several of the obstinate varieties of ulcers resulting from various causes, and have yet to record a failure.

Eight months after discharging this case Mr. H. wrote me that his limb was perfectly well and sound, and that from the first dressing received at my hands it had never given him a moment's pain.

Chronic gout, while not a fatal disease *per se*, is a dangerous affection, on account of atheroma and involvement of the kidneys; depending as it is upon an increase of urate of soda in the blood depositing itself in certain joints and internal organs. These deposits consist of sodium urate, sodium chloride and calcium phosphate. The entire arterial system is apt to become atheromatous, causing hypertrophy of the left ventricle of the heart. The treatment, therefore, is plain. Active exercise; bowels must be kept open daily. Hot baths are of service. Alcoholics should be interdicted. Among drugs, besides alkalines, colchicum and iodine are the best; salicylate of sodium is very useful. A preparation containing colchicine, decandrine, solanine, iodic acid and sodium salicylate in a cordial known to the profession as Henry's Tri-Iodides meets not only all indications, but has clinically proved itself the most useful combination ever offered.

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., OCTOBER, 1897.

No. 10.

CLINICAL LECTURE.

CLINIC ON DISEASES OF CHILDREN.*

By AUGUST SEIBERT, M. D., of New York,

Professor of Diseases of Children, Visiting Physician to St. Francis' Hospital, Physician to the Children's Department of the German Dispensary.

GENTLEMEN:—In the cases that I shall present to you this morning, I shall endeavor to bring out only such points as will be practical and such as you can use in the following of your profession.

CASE I.—ICTERUS.

I have a specimen of urine which I wish you to examine carefully; by holding it up to the light you will notice a general discoloration. You can observe that the child here present, who passed this urine, has a general discoloration of the eyeballs; whether the icterus is present over the body I do not know. On palpation contraction of the abdominal walls makes it almost impossible to feel the liver, but the discoloration of the eyeballs may be observed before any change is noticeable in the liver. The tongue is slightly coated.

Icterus, like epilepsy and enuresis, is a symptom and not a disease. It may come from disintegration of liver-cells or may be due to some mechanical cause.

* Delivered at the New York Polyclinic Medical School and Hospital, October 15, 1897. Reported expressly for the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

As to icterus in the new-born, I can assure you that reams of paper and gallons of ink have been used in writing of this affection, which can be prevented, and which I have succeeded in preventing—and that, not from the second day, but from the moment of birth. Icterus in the new-born is caused by an infection, coming primarily from the infection of the stomach and intestines through unclean and not aseptic handling of the child's mouth. The child struggles against the finger of the midwife in her attempt to remove mucus which of itself is harmless, and swallows, thereby becoming infected. Whether prepared food, mother's milk, or anything else is taken, pain, curdling stools, etc., follow; and if you study many cases of gastro-enteritis you will find that diarrhoea has followed from the second day after birth. It is very evident that infection of the gall-bladder and bile-duct has taken place.

In regard to treatment, it has been found best to attempt to cure an always existing gastro-duodenal catarrh in such children. I begin by starving the child for a few days by the giving of gruel; I then give calomel and order the daily washing out of the rectum by means of injections, whether diarrhoea or constipation be present. I hold that absorption of the fæces from the lower bowel, as long as the fæces have a grayish color, may more readily occur than if diarrhoea is present. The rational treatment is to clean out the bowels with one or two pints of warm water. Some practitioners believe in Carlsbad or Rochelle salts, which I think irritate the whole intestinal tract and cause increased peristaltic movement. We must try to produce an effect upon certain organs without involving the rest of the body. We must not lose sight of pathogenic organisms in the milk. I forbid for weeks ripe fruit and vegetables in gastric catarrh complicated with icterus. I also insist that these children shall not be fed oftener than three times a day.

CASE II.—DIPHThERIA.

This is an instructive case. I find that there are swollen lymph nodes in the child's neck which we can readily see and feel, but upon inspecting the child's throat there seems to be no swelling at all. The mucous membrane of the soft palate and the posterior and lateral wall of the pharynx are not swollen; still we find this case to be one of beginning diphtheria. My experience has been that these are the very cases in which the Loeffler bacilli predominate. In such cases I inject the antitoxin.

To disinfect my hands I use Labarraque's solution; this destroys the bacilli in one second. Tests have been made which show that it will readily dissolve diphtheria membrane, and it is the only substance known that will do this in a short time. I show you here a bottle containing Labarraque's solution, in which is immersed a piece of boiled albumin, which you will notice will disappear in ten minutes. Labarraque's solution should be used in this boy's throat.

I wish to say a word about sulphur fumes as used by the boards of health in this and in other cities. We know that these germs are to be found most plentiful on the floors and in the carpets, and as the fumes go up there is but little chance of their being destroyed. We had better use this solution even at the risk of destroying upholstery. For a quick and ready method for disinfecting instruments Labarraque's solution is very efficient.

To come back to the boy: these cases show but little rise of temperature and are easy to treat if we use antitoxin promptly. Without the antitoxin the spots will grow and involve the larynx and cause a croupy cough and other signs of respiratory embarrassment that may make it necessary to intubate. If we do not use antitoxin we have to resort to the old method of swabbing with bichloride solution, which is entirely too weak to harm the bacilli, but strong enough to slowly poison the child. I have a word to say about the inhalation of calomel fumes. At a meeting of the American Pediatric Society, held about a year ago, the subject of calomel fumes in laryngeal diphtheria came up, and I listened to reports in its favor. As a matter of fact, can these fumes pass deeply enough to attack and destroy the germs? But, even supposing the fumes could penetrate, would a sufficient quantity be deposited on the membrane to destroy the germs? Can these fumes penetrate to the inner surface of the membrane? It is absolutely impossible to destroy germs in a membrane by depositing a 1 per cent. of bichloride of mercury on top of that membrane, and if we expect that calomel will do it we are deceived. If antitoxin is used early we will have but little use for an intubation set. I have not used intubation tubes for years, and yet the number of cases I have treated recently is greater than formerly. Dr. Dwyer says his income has been reduced because he is now called to see so few cases of intubation; here is the difference between a medical man and a business man: while we work to starve ourselves out, for that is the result of medical science, our friend, the business man, works to starve others out.

CASE III.—TONSILITIS.

In examining the child's throat I use very little force. In this case I find only slight inflammation of the tonsil without visible membrane as yet. Such cases should always be seen the next day, and on that occasion I would advise you to have with you antitoxin and a suitable syringe. I use the smallest quantity and, of course, have it very strong. In a paper read at Montreal I called attention to the importance of using a small amount of the fluid; I never inject less than 3000 units in about one and one-half of the ordinary antitoxin syringes. There is no danger from this treatment, except from injecting air into a vein, and that is very slight; but we must remember that if such an accident does occur the child will be dead in ten minutes or less. It takes very little air to cause death in babies. The child of the doctor in Berlin that died soon after antitoxin was injected, it seems, upon investigation, had just partaken of a hearty meal and vomited while screaming. The *post-mortem* showed the bronchial tubes filled with vomited matter.

CASE IV.—PLEURITIS.

This is a case that you saw last week, when we introduced a needle but failed to withdraw fluid. I then spoke of treatment. Primary pleurisy is of rheumatic origin in the majority of cases. This child has been getting nothing but salicylate of soda and you cannot fail to note the marked improvement.

I wish to present a device of my own for filling a nursing bottle. It consists of an aluminium funnel in which is placed absorbent cotton. This little affair is the result of a whole winter's work; but by this simple method milk may be filtered before sterilizing. You ask how it is possible

to filter milk through absorbent cotton, as all the milk and cream will go through. True, the milk will go through, but the bacteria will remain in the cotton. Given 8000 germs to a cubic centimeter of milk before filtering, we find in the milk after filtering 1000 germs per cubic centimeter. We find that while the digestive apparatus of a child cannot stand 8000 it can easily destroy 1000.

I advise my patients, when traveling, to carry absorbent cotton and to filter the water before drinking.

ORIGINAL ARTICLES.

THE CAUSES, DIAGNOSIS AND PROGNOSIS OF VALVULAR DISEASES OF THE HEART.*

By HAZEL PADGETT, M. D., of Columbia, Tenn.,

Professor of Physiology and General Histology in the University of Tennessee, Medical Department.



R. PRESIDENT AND GENTLEMEN:— I hope that you will pardon me for bringing up such an old and well-known subject as organic valvular cardiac diseases, and their diagnosis, but I feel it is such an important subject that it will bear repeating many times a day. I do not care to weary you with any detailed description of the organic changes in the valves and substance of the heart. You will find them thickened, contorted, adhered and ruptured, in some cases without vegetations and calcareous infiltrations.

I will call your special attention to the cause, diagnosis and prognosis. The presence of organic valvular lesions in the majority of cases is discovered by what clinicians call murmurs. These are abnormal sounds produced in the heart, either by changes in the valves that render them partially or wholly useless, allowing the blood to go back into the cavity from whence it came; hence, the first grand division of murmurs, the regurgitant; or, on the other hand, offering some obstruction to the onward flow of the blood in its natural course. Hence, we get to the second grand division, called obstructive murmurs; or we may have and do have murmurs in certain low vital conditions and blood diseases independent of any change or changes in the valve or valves. These are called hæmic or blood murmurs. The quality of murmurs differs very widely, and such a wide variation in their quality and intensity that I am rather fond of imitating them with certain sounds produced by the mouth. We have the

* Read before Tri-State Medical Society of Alabama, Georgia and Tennessee, at Nashville, Oct. 13, 1897.

low blowing, the harsh grating, and the whistling, in their different intensities. Any valve of the heart can be so affected as to produce an organic murmur, but some valves are more susceptible to the influence of disease than others—and it is the valves of the left heart that we usually find affected; yet we do find some primary lesions in the right heart. But murmurs in the right heart are usually secondary to the left-side murmur. Allow me to state, that in some cases of murmurs, when our diagnosis has been an organic murmur, the *post-mortem* fails to reveal any valvular change. The relative frequency of cardiac murmurs, in the order of their occurrence, are: 1st, mitral regurgitant or reflux; 2d, aortic obstructive; 3d, aortic regurgitation or reflux; 4th, mitral obstructive or stenosis. These are the common murmurs, ones that usually concern us. But, making the list complete, we have: 5th, tricuspid reflux; 6th, tricuspid stenosis; 7th, pulmonary stenosis; and, 8th, pulmonary reflux. Yet, as I have said, these last four are very rare.

We have combinations of the different murmurs, and the most common ones are: 1st, aortic stenosis and reflux; 2d, mitral stenosis and reflux.

Of all the causes of endocarditis, acute rheumatic fever stands at the head, with a record of from thirty to sixty per cent. The poison of this disease has a peculiar affinity for serous membranes, and especially the endocardium. So, we cannot be too careful in examining the hearts of our acute rheumatic fever patients from day to day, if from no other reason than to know and to tell our patients that their hearts have escaped during the attack. We have murmurs develop from the effects of an ulcerative endocarditis impairing the integrity of the valves; but we usually hear these murmurs, when they exist, only for a very short time; for ulcerative endocarditis is almost always fatal. Many of the acute infectious diseases at times produce an endocarditis resulting in a murmur or murmurs. Such are seen at times in diphtheria, scarlatina, erysipelas, typhoid fever and small-pox. There are a number of diseases that place the body in such a state that they create a predisposition to endocarditis: such are seen in cancer, syphilis, diabetes, gout, and, at the head of the list, Bright's disease. I have seen valvular lesions so often in very young children that I have been led to believe that there may be more congenital valvular lesions or intra-uterine endocarditis than we are aware of. And, independent of the above-named causes, in the degeneration of tissues of old age, the valves or valve become thickened and incompetent. Muscular efforts producing great tension of the valves, which in time develop an endocarditis or, rather, a murmur or murmurs. In examining the heart and discovering a murmur or murmurs the question arises: What kind of a murmur have we, and what valve is affected? The only way by which we can diagnose the murmur is by "timeing" it. Does it occur during the first sound, with the second, or just before the first? are questions that naturally arise while auscultating the heart. We must not forget the fact that a murmur or murmurs may replace a sound or all the sounds of the heart. The sounds of the heart in some individuals are so plain that you can hear them very well through an ordinary amount of clothing, but if there is any obscurity whatever in the clearness of the sounds, it is always much safer to remove the clothing; and from the non-observance of this little procedure

many valvular lesions are overlooked and the heart pronounced sound, and it may remain for some one else to discover the murmur.

Having discovered a murmur, there are three elements that we must consider in making the diagnosis: 1st, is it a systolic, diastolic or presystolic? 2d, the point of maximum intensity; and, 3d, its transmission, if any. I have examined the hearts of patients while in the standing or sitting posture; and while there was no distinct murmur, yet the sounds of the heart were not of that smooth and even character. This attracting my attention, I have caused them to assume the horizontal position, and then a murmur was heard, clear and distinct. I have seen this so often that if there is any obscurity whatever in the sounds of the heart, I make the person assume the horizontal position, especially in the examinations for life insurance. I claim this a very practical point in the diagnosis of murmurs, and I feel that we would all be very much benefited if we would pay more attention to it. When I suspect some organic disease, and the sounds of the heart are not as distinct as they ought to be, yet I have heard no murmur, when the organ was auscultated in the different postures, I cause my patient, if he can, or the applicant for life insurance, to take a little exercise, walk rapidly around the room, up and down the steps, so as to increase somewhat the force of the heart, and under these circumstances the murmur was brought to light.

These points, as insignificant as they may seem, have rendered me invaluable aid in the diagnosis of murmur. I think that if there is anything practical in physical examinations, it is here. Independent, many times, of what the patient or person may tell you, the physician is able to make a diagnosis clear-cut and distinct, for signs and changes speak for themselves.

The next question arises: What valve is affected? A mitral regurgitant, systolic in time, heard at apex; transmitted to the left axilla and heard at inferior angle of left scapula. When a mitral murmur is not very distinct, and we desire to hear it better, use the simple means I have already mentioned. I frequently cause the person to take a forced inspiration and then a forced expiration, and suspend respiration, and many of those faint and obscure mitral murmurs are heard without any trouble, clear and distinct. The quality of the murmur varies greatly, from the faintest and softest to the loudest blowing, whistling and grating. In mitral stenosis there is a loud presystolic murmur of the quality of grinding, blubbery and churning. The length of this murmur is longer than any other, because it takes the blood so long to pass the narrow orifice. Heard best at apex or a little above; presystolic and not transmitted. An aortic stenosis is seen from the slightest narrowing to a mere button-hole slit, producing murmurs of wide variations. Some murmurs are so slight that I could only satisfactorily hear them while the person was in a recumbent position and holding his breath in a forced expiration. This murmur heard best at about the junction of the second costal cartilage with sternum, or below that point; transmitted in the course of the large arteries of the neck, and systolic in time. An aortic reflux heard at base, as the above; diastolic, and transmitted down the sternum. Heard from a faint to a very loud-blowing murmur.

I would like to state that I have confined myself to the auscultation of murmurs, and have not mentioned many of the other well-known concom-

itant symptoms of a valvular lesion, for the reason that I would go beyond the limits of time of the society and would make a paper too long, and I have presented the subject as I have seen it in every-day life.

In coming to the last division of our subject, that of prognosis, do not let us be too hasty in pronouncing the benediction upon the usefulness and activities of a man's life by telling him that he has "heart disease." If there is anything that will take all the beauties of life away and surround an individual in a cloud of gloom and make him, a man once so happy, one now so miserable, it is to tell him that he has that dreaded monster—"heart disease." One who has never drank the contents of that bitter cup can never realize that awful picture, portraying the darkest side of everything in life. Upon every object, in his every thought, and even in his dreams, he sees the words "heart disease and sudden death" standing out in bold relief. To live in such a state is to have a maddened demon haunting you day unto day, and night unto night, till death itself would be a sweet relief. I believe I can truthfully make the same remark concerning the prognosis of valvular lesions as the one I heard the immortal Forrad make in speaking of the prognosis of Bright's disease, when he said many patients will live for years when you have expected yearly their death, and then Bright's disease did not kill them. How often have I found organic valvular lesions in individuals who have never experienced any inconvenience whatever, enduring severe and prolonged muscular exertion every day. I say that it is criminal, under these conditions, to tell him voluntarily that he has "heart disease," just because you have discovered it. It is well enough to tell some one who is directly interested in him. Doubtless many people carry their lesions for years, and that in itself never caused their death.

In forming our prognosis there are several very important points for us to consider. Does this lesion produce any symptoms or inconveniences at all? If so, what are they and their extent? Has the heart compensated? What is the condition of the arterial tree and the kidneys; and what is the probable extent of damage to the valve or valves? This last we are not always able to tell, because the loudest and longest murmur does not always indicate the most extensive lesion of that particular valve. But even taking all these facts into consideration, lesions of certain valves are more dangerous than others. Aortic reflux is the most dangerous, and akin to it is mitral stenosis. Acute cardiac failure is a condition that often arises in the different valvular lesions, when the person had never experienced any or little trouble therefrom. I wish to relate a few cases illustrative of some points mentioned in the paper:

CASE 1.—E. H., age 23, blacksmith. Always in good physical condition. Was called to see him and found him sitting up eating soup. He told me for about two days he had felt a little bad; had taken a couple of cathartic pills. I found him with a cold skin, bathed in cold perspiration; accelerated respiration. Pulseless the greater part of my first visit, but now and then a mere wave would reach the finger. Cardiac pulsations between 120 and 130, with a very faint and indistinct mitral reflux. All other organs in body normal except the one named. No fever. I diagnosed an acute cardiac failure; placed patient upon an appropriate treatment; he responded nicely, and in forty-eight hours was ready for work, as usual.

Previous to this time there had never been any sign or symptoms of organic cardiac lesion. The patient was a hard-working man.

CASE 2.—Mrs. N. G., age 28. One year before had an abortion and afterwards a pelvic peritonitis, but had fairly recovered her health. Has a mitral regurgitant of an indistinct character, and upon several occasions during the past twelve months had a little difficulty of breathing and palpitation, but no dropsy or œdema. Early one morning she was seized suddenly, without any previous warning of the coming storm, with dyspnœa and palpitation, which grew rapidly worse. Respirations high, cardiac pulsations 150 deg., and at times pulseless. At this time a little œdema appeared in feet, but nowhere else. I diagnosed an acute cardiac failure. Placed patient upon proper treatment, and in a few days she was as well as usual.

CASE 3.—C. B., age 55. Had always been an exceedingly healthy man; never had had any illness; used to excessive exercise, walking up the sides of mountains in North Carolina without any trouble or fatigue. A few months before consulting his physician he noticed a shortness of breath, which alarmed him. The exercise he has been so accustomed to would now fatigue him. Upon examining his heart an aortic stenosis was detected. One day, while sitting perfectly quiet, and no unusual signs or symptoms preceding, he fell over dead. The *post-mortem* examination revealed an exceedingly thick aortic orifice, immovable valve, almost solid calcareous matter, with a very narrow button-hole slit. Judging from the anatomical changes noticed in the valves by me, I would say that it took not less than fifteen years to produce those changes.

CASE 4.—H. B. W., age 21. Has had for a number of years, and probably since childhood, an aortic regurgitation. Heart is excessively hypertrophied—so much so that he has the typical beefy heart. Had never guarded himself in his plays while a boy; would indulge in the sports with the other boys. From time to time in the past four or five years has had several spells of severe palpitation. You can count the pulsations by placing your hand upon any part of his person, and you can also count the cardiac pulsations when the patient is upon one side of the bed and you on the other, without even touching the patient. The cardiac stroke is transmitted to the bed, and simply by applying your hand to the bed you are able to count the pulse. At this particular time the young man is enjoying life to its fullest.

Dr. Loomis relates a case of aortic reflux of an extensive character who lived through three attacks of croupous pneumonia.

District Medical Society of Central Illinois.—The twenty-third semi-annual meeting of the District Medical Society of Central Illinois was held in Taylorville, October 26th, with a very good attendance. The following papers were read and discussed: "A Case of Oophoritis," by Dr. William Thompson, of Cerro Gordo; "Report of a Case of Traumatism of the Eye," by Dr. James M. Ball, of St. Louis; "Mechanical Causes of Sickness," by Dr. W. J. Chenowith, of Decatur; "Dermoid Cyst," by Dr. W. M. Catto, of Decatur; "A Case of Erythromelalgia," by Dr. W. J. Eddy, of Shelbyville. The next meeting will be held in Pana in April.

PRESIDENTIAL ADDRESS.*

By THOMAS HUNT STUCKEY, M. D., of Louisville,
Professor of Theory and Practice of Medicine in the Hospital College of Medicine,
Louisville.



EVEN YEARS have passed since you were in Kentucky. That is a longer time than we would have wished; but the delay has served only to heighten the pleasure we feel at your coming and increase the warmth of the welcome we now extend to you. In the days of our fathers, the days of the Old South, the traveler along our country roads had no fear of lack of entertainment when nightfall came upon him. At the gate of the first house he reached he halted. A cheery call came to him to "light and hitch." One colored boy took his horse, another led him to the guest-

chamber and arranged his bath and clothing. When the supper hour arrived he found no extra plate had been laid for him, because such extra plates were always in readiness upon the table.

Time has brought changes since then. Experience has taught us to be chary of the chance stranger; but believe me that I speak for our whole people when I say that, when the visitors are our friends and honored associates, as you are, gentlemen, our homes and our hearts are as open to you as ever they were in the bygone days.

This spot, near the center of the Mississippi valley, seems indeed a fitting one for the meeting of the Mississippi Valley Medical Association. A parallel between the intellectual and the physical features of this central section of our country is at once suggested. From Minnesota to the gulf, the world's greatest channel of commerce sweeps with force. From the Eastern mountains and across the Western plains flow in the tributaries, bearing the products that help to feed and clothe the world and add to the riches of the country and the peace and plenty of the people. New England is great in history. It is now but a tiny corner of a land, each part of which equals it in all that makes for greatness. East of the Alleghenies lies a strip too narrow for the development of commanding power. The golden dream of the Pacific slope attained its ultimate decades ago. The physical, financial and commercial future of the country lies between the Alleghenies and the Rockies. And here, too, I believe will be found the intellectual forces which, in the years to come, will lead this country, and through it the world.

The valley of the Mississippi is an empire in itself, and its sons will be rulers in the coming years. Narrowing this line of thought to our own profession, look at the champions set forth by us to win undying honor in

* Delivered before the Mississippi Valley Medical Association, October 5, 1897, at Louisville.

the warfare against suffering and death. In a million homes to-day a mother's care is not missing, and there is happiness instead of mourning because Georgia gave to the world Robert Battey; Kentucky, Ephraim McDowell; and Alabama, J. Marion Sims, the father of gynæcology. In the ranks of general surgery, what names are written in brighter letters than those of Gross and Miles and Scott, of Louisiana; Hodgen, of Missouri; Brashear, Dudley and Yandell, of Kentucky, and Briggs, of Tennessee. In general medicine, we look back to the Flints, Gaillard Thomas, Lunsford Yandell, Bush, Henry Dixon, T. S. Bell and Harvey, of Indiana.

These men are of the past, it may be said. But are we retrograding? Think of Senn, Murphy, Bernays, Walker, Parker, Reed, Owen, Wyeth, Gibney, Humiston, and our own beloved Mathews. Have we not cause for pride?

I have singled out these men with difficulty; not because each and every one of them does not deserve eulogiums beyond the power to bestow, but there are in our ranks so many men of fine gifts and masterly attainments, that it seems hardly fair to mention one without naming all. That a few do not stand out pre-eminent is not due to any lack of excellence; it is because the standard of general medicine is so high that the ablest do not tower above their fellows, as they once did.

To revert to the present gathering, I miss, in looking about me, many familiar faces. They are the faces of men whose absence we would deplore from a selfish standpoint; but we honor them in their absence even more than we would welcome their presence. For the missing ones are our brethren in the stricken cities farther South. They are fighting the good fight against the yellow scourge of their people, and are making one more proud chapter in the history of medicine in the Mississippi Valley. We would gladly have them with us, but their duty holds them at their posts of danger, and our regret at their absence is lessened by the knowledge of their brave well-doing.

Pardon my introduction of personal feeling, however, when I say that one man is missing from among us whose absence causes sorrow that is unqualified. Were there with us now, as in the past, that model of manliness, that sunny soul, whose like we shall not look on soon again—if Edward Palmer were still alive, the memories of your present visit would be brighter and more joyous in the years to come. In our crowded profession few men could leave such a gap and one so hard to fill. Many of you knew him in his professional usefulness; more of you knew him as a man among men. You will, I am sure, share in our sorrow at his sudden taking off, which the passage of many months has not dulled, and will echo this passing tribute to one we knew and loved so well.

And now, gentlemen, in conclusion, let me repeat that we are proud and happy to have you with us. We will hardly be able to convert you to the doctrine, which is a cardinal belief with every son of our soil, that the Lord devoted five and a half days to making Kentucky before He began on the rest of the world. Your stay will be too short, but we will do our best.

THE ADMINISTRATION OF QUININE TO YOUNG CHILDREN.

By S. M. WARD, M. D., of Hampton, N. H.,
Late Visiting Physician to the Home for the Friendless, Scranton, Pa.



ONCERNING the administration of quinine, a recent number of the *Deut. Med. Woch.* contains an article of the celebrated Professor Binz, wherein he recommends the following methods: Inunction, suppository and rectal injection, and hypodermically. If none of these methods seem applicable, he suggests the use of the tannate or quinine chocolate. It is for the reason that I believe failure will result in a majority of cases in the treatment of infantile malaria by any or all of these expedients, and because experience has taught me a sure and pleasant manner of using the in-

valuable—though atrociously bitter—cinchona salt, that I am constrained to notice the Professor's article, and make some comments thereon. I would first remark that I am unable to understand the meaning of the statement with which he begins his article, viz.: "Children of three years and upwards are able to swallow the half grain and grain gelatine-coated quinine pills found in the shops, and those younger may be taught to do so." A fanciful assertion, as most of us know, and one which if true renders further remarks superfluous. The use of quinine hypodermically is fraught with danger. I believe an abscess is almost sure to follow, and, if not, the pain is so great as to render it an impracticable method of medicating young children.

As to inunction, full well I know that an ointment of from 20 to 30 grains of sulph. of quinine to the ounce, as *e. g.*:

℞ Quinine sulph.....	ʒss
Vaseline.....	ʒii
Lanoline.....	ʒvi
M. Ft. ungt.	

well rubbed in, especially at the flanks and arm-pits, will frequently cause a disappearance of the malarial phenomena, but it is a dirty method, and produces very often a dermatitis, precluding its use more than once or twice on the same patient. As to introducing quinine or any other medicament into the system of a young child via the rectum, while not denying that it may be possible in German children, I am sure it isn't in most American ones. After several futile attempts to introduce a suppository into the rectum of a boy of six or eight years, I had given up the attempt until, in a case of dysentery, being very desirous of getting the local effect of nitrate of silver, I did manage to get one to stay by waiting till the child

was sleeping soundly. Never have my efforts to have a child younger than ten years retain either nutriment or medicine in the rectum been successful unless I took advantage of it in some way. Admitting that a rectal injection or suppository of quinine sulph. is potent, I also believe it practically impossible to take advantage of the method, save in rare instances. As for the tannate of quinine, only one-third of it is potent, even at the best, and it is, even at that, far from pleasant. The chocolate preparation will do in some cases, but it is very expensive; and outside of large cities, I have never been able to obtain it. We have a preparation of cinchona, most eligible for use with young children and adults who have pills "stick in their throats," and whose stomachs rebel at the nauseous, extemporaneous mixtures usually prescribed. I refer to "Febriline, or syr. of tasteless quinine," made in St. Louis. Having used pounds and pounds of it, I speak only what I know when I state that time and again have I successfully treated children of but a few months of age with it. I learned of it some dozen years ago when nonplussed over a case of intermittent fever; patient, a boy of two and a half years, who could not swallow pills or capsules, in whom an ointment much stronger than the one given failed to do more than produce a beautiful "rash". He could not or would not control the anal sphincter to an extent more than to admit a syringe-point. In him also arsenic produced no effect, and he vomited not only my elegant (sic.) quinine mixtures, but everything else, and his condition was becoming critical. It was with much anxiety that I awaited the arrival, and the tentative teaspoonful of Febriline, not at all reassured by its foggy appearance. The claim is made that each dram contains the equivalent of two grains of sulphate of quinine, and that if taken clear, a little water being swallowed immediately thereafter, no bitter taste is developed. I cannot affirm the first statement farther than to say there must be some cinchona in it for (*a*) it cures malarial manifestations; and (*b*) if a bit of acid is added to it, no quinine mixture I ever tasted makes one more *bitterly* repent. Of one's mouth may be said, with slight changes, what Tom Moore sang of the rose: the "taste of the quinine hangs 'round it still." I gave the patient alluded to four ounces of Febriline; never once did it cause gastric disturbance or any other; never was there any trouble in getting him to take it. Since then I have duplicated and reduplicated this experience. It is strange that so pleasant and potent a preparation is not more widely known. I have recommended it to a number of physicians, and all have spoken highly of it in every way. It is expensive, the only drawback to an extended use. I may say that a "smart Alec" of a druggist proposed to demonstrate to me that it was a syrup of the tannate of quinine, when, behold! the muriated tincture of iron threw down no deposit, though the experiment did the druggist. In closing, permit me to say that I have no interest in this preparation, directly or otherwise; that I do not know who makes it, nor do the proprietors know me; and, finally, if they ever know this article is written it will be by reading it in some medical publication.

PATHOGENESIS AND TREATMENT OF A VERY GRAVE CASE OF DERMATITIS CONSECUTIVE TO TWO APPLICATIONS OF X-RAYS.*

By DR. G. APOSTOLI, of Paris.

[TRANSLATED BY FRANK RING, M. D., OF SAINT LOUIS.]



HAVE just presented to your examination a case of dermatitis, with neuritis, following two applications of X-rays. This is the most grave and rebellious case which I have met up to the present, and for which I advance a new method of treatment. I present a summary of the history, as follows: It concerns a very large point of gangrene of the abdominal wall, which in February last measured 17.7 centimeters by 13.6 centimeters, and was a sequel to two applications of the X-rays, made at Dublin the 22d and the 28th of May, 1896.

At the first seance, of forty minutes' duration, the Crookes' tube was fifteen centimeters from the skin; in the second, of ninety minutes' duration, the tube was at nine centimeters distance.

Immediate Effects.—Several consecutive attacks of nausea after each seance, but no vomiting.

Subsequent Effects.—Appearance two days after the last seance of a progressive erythema which was aggravating.

Vesicles and consecutive phlyctenulæ with abundant serous flow.

Progressive formation of an eschar.

In July, notable amelioration.

In August, relapse with new mortification, with the appearance of a burn and intense pain at the level of the mortified surface. Successive application of all the lotions, topical applications and caustics known, even the addition of skin grafting, and the practice of curetting under anæsthesia, all with the same constant and absolute lack of success during eight months.

From the end of October, 1896, the daily local application of a current of oxygen upon the wound, during five hours every day, is the only treatment which appears to act favorably and to arrest the increasing growth of the wound without ever making it recede sensibly.

February 9, 1897, commencement of electric treatment, applied with the assistance of Dr. Planet, and which may be described thus: Daily static baths with emanations upon the part during all the seance of twenty to thirty minutes.

End of March, addition to the static bath of the application of the currents of high frequency in the form of the electric condenser.

* International Medical Congress, at Moscow, August, 1897.

From April, 1897, semi-weekly use of hydro-electric baths with the undulating current.

Progressive improvement from the commencement of the electric treatment, and especially since the association of static emanation, with the polar applications of the undulating current. Very slow, but progressive detachment of the dry and very adherent eschar and actual reduction (August, 1897,) to about one centimeter and a half square.

This little portion of eschar will surely disappear before the end of the present month. Such as it is, it suffices to show the extreme gravity of the primitive lesion, and the extension of the process of mortification toward the deep parts (the burn had attained the subcutaneous cellular tissue).

The spontaneous fall of the eschar, provoked by my treatment, has been the first course of the cure. Now that this result, the most important, in my eyes, is finally obtained, one may see a wound of which the greatest part is covered with red carnal buds of a healthy nature and of which the periphery presents an invading cicatricial band.

The cicatricial process appeared equally around the umbilicus, which is completely filled up. The patient is thus in plain view of cure, as will be testified, besides, by the photographs which I herewith present to you, and the treatment, although very long and very laborious, will shortly be terminated without any new incident to chronicle. I append the conclusions to be formulated on this subject:

First. The radiograph can provoke, under certain circumstances, a dermatitis, with neuritis, more or less grave, characterized either by a simple erythema, or an eschar more or less deep, involving the skin even to the subcutaneous cellular tissue.

Second. This dermatitis, variable according to its site (skin, nails, hair), variable also in a certain measure, according to the constitutional condition of the patient, may be compared to an ordinary electric burn, and presents the same general characteristics of asepsis, apyrexia, of a very slow evolution toward repair, and of nearly equal intensity in all its extent.

Third. This dermatitis is always the result of a fault in operative procedure, committed either and above all by bringing the Crookes' tube too near the skin, or by a too long duration of a single sitting, or, finally, by too many seances too closely repeated.

Fourth. According to the experience of Messrs. Destot, Balthazard, and De Tarchanoff, it seems to be demonstrated that these accidents must be attributed, not to the inoffensive X-rays themselves, but to the electric emanations engendered by Crookes' vessel (*ampoule*).

Hence, the supplementary necessity of suppressing these emanations with a mercurial vibrator, or to intercept them with a leaf of aluminum connected with the earth, thereby allowing the X-rays to pass, and arresting the only dangerous rays, *i. e.*, the electric rays.

Fifth. I propose as efficacious treatment of this rebellious dermatitis the electric current, which will comprise the following method, which one can associate as to variable intensity and duration according to clinical indications:

(a) The simple static emanation (*effluvation*) which, by its direct and

local action, aided by its general influence, hastens the work of reparation and the cicatrization of ulcers.

(*b*) The polar application of a galvanic current—or better, an undulating current—in order to accelerate the falling of the eschar, and thus favor the ulterior topic and trophic action of the static emanation.

(*c*) The general action of a current of high frequency (by means of the electric condenser), destined, as has been demonstrated by Professor d'Arsonval, to relieve the co-efficient of the general nutrition and to carry to the economy a supplement of force and of vitality.

BLENORRHOEA OF THE LACHRYMAL-SAC, DACRYOCYSTITIS, AND STRICTURE OF THE TEAR-DUCT.*

By E. H. BRADLEY, M. D., of Peoria, Ill.



VERY specialist is well aware how difficult it is to interest the general practitioner by the recital of some subject pertaining to some one of the specialties. Still, I feel justified in calling your attention to a trouble of great importance. The health of the masses is under the watchful care of the family physician. In the great majority of families it is expected that he will call their attention to small matters that may at some future time be of great moment. I wish to speak of blenorrhœa of the lachrymal sac, dacryocystitis, and stricture of the tear-duct. By a blenorrhœa of the

tear-sac we understand a catarrhal inflammation of the mucous membrane, in which the secretion is deposited upon the surface only. This diseased condition is brought about in several ways:

1. It may be the result of a severe conjunctivitis. 2. "Catching cold." 3. Acute and chronic infectious diseases of the eye. 4. Stricture of the tear-duct. 5. Diseased conditions within the nose. 6. Sex (much crying; females indulging in this little pastime more frequently). 7. Erysipelas. 8. Syphilis. 9. Tuberculosis. 10. Injuries. 11. Conformation (flat sunken bridges).

Dacryocystitis consists in an inflammation of the connective tissue surrounding the sac, resulting in a purulent disintegration of the sub-mucous tissue, with the formation of an abscess which ruptures externally.

The connection between the two diseases is that the blenorrhœa precedes the dacryocystitis and gives rise to it. The sac being filled with

* Read before Peoria City Medical Society.

purulent secretion, it only will require a small defect in the epithelial lining of the mucous membrane to permit of the penetration of the micro-organisms present in the secretion, whence they excite a purulent inflammation.

Constriction of the lachrymal duct develops usually as the result of (*a*) inflammation of the nasal mucous membrane. Under this head may be mentioned acute and chronic catarrh, whether one of simple nature or one of scrofulous or syphilitic origin. The swelling of the submucous cavernous tissue may reach such a high degree as to press upon or by continuity cause closure of the duct and, later, stricture. (*b*) In the atrophic form of rhinitis we have no swelling, but a general cicatricial contraction of the whole mucous membrane of the nose, which may continue from the lower orifice into the duct itself, and thus lead to narrowing of its lumen. (*c*) Ulcers, by their healing and consequent cicatricial contraction. (*d*) Tumors, as polypi and exostoses, closing the lower orifice.

Blenorrhœa of the lachrymal sac is a very chronic disease extending over years. A spontaneous cure may occur, when the lumen of the duct becomes free once more. This occurs very rarely. The rule is that no cure takes place without artificial interference, but the following course is run:

The secretion, at first purulent, becomes, after some time, mucous and viscid, and after a time, in consequence of atrophy of the mucous membrane, ceases entirely. Then the distended sac contains simply the tears. This distension of sac may keep on increasing until it assumes large proportions. The epiphora continues because of the constriction of the duct below.

Blenorrhœa may be recognized by epiphora, slight fullness in inner corner of eye, and upon firm pressure over this fullness the secretion will be caused to exude from the punctum. The great danger to be apprehended from this condition is infection of the cornea. It stands as a constant menace to the welfare of an eye, even a slight injury causing an abrasion of the corneal epithelium, for infection will most certainly take place.

Dacryocystitis will be recognized by great swelling, redness and pain, accompanied by elevation of temperature and, later on, formation of an abscess, which if left to itself breaks externally. Pressure causes the appearance of pus at the inner canthus.

The treatment of blenorrhœa will consist of frequent washing out of the sac with some antiseptic astringent. To do this it will be advisable to slit up the canaliculi.

In the great majority of cases there will be found a stricture in the duct. It is a question whether it will be advisable to commence at once the probing of this stricture, so as to open the duct and give drainage to the sac, or to wait until such time that the blenorrhœa is partly under control; for fear that in the probing the mucous lining of the sac be injured and thus make free a point of inoculation, with the danger of a resulting dacryocystitis. Although it may be inadvisable to pass the probe for the reason suggested, still I have been in the habit of doing so, and so far have seen no ill results.

In the treatment of dacryocystitis, if seen early, it will be advisable to make an effort to abort the disease; failing in this the abscess may be opened. The discharge, first purulent, afterwards semi-purulent, finally, as

the trouble progresses to resolution, becomes clear and watery. The fistulous tract formed as the result of the passage of tears will in most cases close.

As soon as the active stage of the disease has passed the duct below should be opened by frequent probing.

In those cases of blenorrhœa and dacryocystitis, where frequent cleansing and probing does not result in a return to the normal, it will be necessary to remove the sac.

This, as taught in all text-books, consists in dissecting out the sac and then packing the cavity and allowing it to heal by granulation. The space between the eyeball and the bony wall of the nose being small, and the bottom of sac very deep, it is very difficult, owing to the usually great bleeding, to be able to say that the whole of the sac has been removed. Not being certain that we have removed it all, it is advised to cauterize the bottom of the wound.

In my last two operations I have followed a procedure, suggested to myself, which I think a vast improvement over the former mode of operation.

I first prepare the part for operation by injecting into the sac sterilized gelatin, made intensely blue by adding to it a small quantity of pyoktanine. The gelatin is heated so as to make it liquid, and then with a small pointed drop-glass the sac is injected to distension. In a few minutes it has become semi-solid. This injection assists in two ways: First, by giving a landmark to the boundaries of the sac; and, second, the intense blue enables the eye to direct nicely the scalpel just outside the wall of the sac.

To preserve the usefulness of the lachrymal apparatus, I then place through the upper canaliculus, and down into the bony tract of the duct, a gold tube; then by three or four stitches bring together the wound. Union taking place in a few days' time, we have accomplished what requires two or more weeks by the usual method, besides preserving the patulancy of the duct.

The tube is best made of pure silver and then gold plated. Being of silver, it is very readily molded to any desired shape; and in putting in tubes in these and other cases of simple stricture, I find the tube works better when put through the upper canaliculus. Here it is a little above the angle of the canthus, and mucus is less likely to collect in the opening. Not only this, but I also find that the frequent movement of the upper lid in the act of winking brushes over the opening of the tube, when properly put in, and so keeps it free from any discharge that may be liable to collect.

These tubes are worn without inconvenience, and take the place very nicely of the normal condition.

I intend some time in the future to try the insertion, in place of the gold-plated tube, of a freshly prepared thigh-bone of a small frog, in the hope union may take place followed by partial absorption, and so keep free drainage into the nose.

Growing.—The TRI-STATE MEDICAL JOURNAL is one of the few monthly medical journals which are growing. We average over one hundred new subscribers every month.

A MEMOIR ON THE ODORIFEROUS SENSE.

By J. MOUNT BLEYER, M. D., F. R. A. M. S., of New York City.



THE CLOSER analysis of these simple observations leads us to correct conclusions regarding the conditions of smelling. First, it is obvious that, together with atmospheric air, only such substances reach the mucous membrane of the nose which can be contained in the former, which are blended with it in an aerial form, whether they be originally gases, or changed into such, in the form of steam or vapor, from a solid or liquid state. Solid or liquid bodies which become gaseous at an ordinary or only at a high temperature, are, as is well known, called *volatile*. Neither a liquid nor a solid *substance*, even if pos-

sessed of the necessary properties, can, under ordinary circumstances, penetrate the nose and cause there a sensation of smell. The question then arises whether there are among the non-volatile, solid or liquid bodies such as would be able, when brought in contact with the mucous membrane of the nose, to affect the nerves of smell; it appearing probable that we only, therefore, never smell the non-volatile bodies, because the ordinary carrier of odorous substances, the air, cannot convey them to the nose. The question can be answered and is solved by very simple experiments: solid bodies can be blown into the nasal cavity, as powders, for instance; liquid substances can be brushed, squirted, and poured into it, as will be demonstrated when it becomes manifest whether they produce sensations of smell. Experiments of this kind have established it as a law, which knows no exception, that *all non-volatile bodies are odorless*, being devoid of that unknown property which is the exciting element for the nerve of smell. Only originally gaseous or volatile substances are smellable. But that the gaseous or volatile state is not the only condition which enables a substance to affect the nerve of smell is proved with certainty by the fact, already alluded to, that not all gaseous or volatile substances are smellable; as, for instance, the odorless oxygen or carbon—and among the latter, water. There must, therefore, be another condition, besides the one already mentioned, to render a gaseous or volatile substance odorous, and that most essential condition is the great unsolved enigma. Another question is whether the volatile or gaseous substances, which experience teaches to be odorous, can only then act excitingly on the nerves of smell when they touch the mucous membrane of the nose in an aerial state, or whether they evince the same faculty also when dissolved in water. One is inclined to expect with certainty a smelling effect also in the latter case, as every odorous substance, even when coming in contact with the mucous membrane in a gaseous state, is probably imbibed by the vesicles of the epi-

thelium, from which it acts upon the nerves only after being dissolved in the moisture of the mucous membrane, and as it would seem proper to assume that such a substance would preserve, in a liquid solution, all its essential qualities. The question is not so easily solved as would appear at the first glance, and therefore not yet solved with complete certainty. In a surprising way the experiments made prove more against than in favor of the smellability of odorous substances in liquid solution; but as in most cases there is a strong presumption of the possible existence of other reasons for inodorousness than the state of solution, no decided judgment ought to be formed. I shall only briefly indicate the way of proceeding, what regards must be had, and what precautions taken. If only the mucous membrane of the nose was wetted or moistened with the liquid solution of an odorous substance, it could by no means be concluded from the resulting sensation of smell that the liquid solution has been effective, as while, besides it, there is air in the nasal cavity, a part of the odorous substance combines with it, thus coming in contact with the mucous membrane also in an aerial state. The first condition of such experiments will, therefore, be to exclude from the nasal cavity all air which could absorb a part of the odorous substance from the solution, and to fill up with the latter the whole cavity. Such a filling up of the nose with liquid will probably appear to a novice not only as a very disagreeable experiment, but also as impracticable. Neither the one nor the other is really the case, as I can assure from experience: the experiment is very easily made, and neither painful nor in any other way particularly disagreeable; it by no means belongs to the list of torturings with which physiologists are so eagerly reproachable. Let a man recline upon a long table and so hang down his head off the edge as to have the nostrils turned upward, and another will be able to completely fill up each of the latter with water abundantly poured into them. The liquid remains in the nostrils as in a tumbler, without flowing down, as it would be expected, in the throat, which is in open communication with the nasal cavity, of which breathing through the nose alone is a sufficient evidence. The mechanism which interrupts this communication, and forms a close partition between the nasal and guttural cavities, is the following:

SONNET.

LIFE'S SPECTRUM.

When through a lens, cut in prismatic form,
 A ray of pure white light is made to pass,
 It breaks in colors through the angled glass,
 As sunbeams through the drops of passing storm.
 Thus is it known that light, diffused and white,
 Combines the seven colors of the bow—
 Red, orange, yellow, green, blue, indigo
 And violet—in order thus unite.
 'Tis thus with life, where all is clear, serene,
 The lens of sorrow breaks it into hues
 Of varied color, and this truth is seen:
No perfect life a single shade may lose!
 And if our hearts arrange the shades aright,
 God's chromoscope will whirl them into white.

THOMAS OSMOND SUMMERS, in *St. Louis Clinique*.

UNNA'S SCHOOL OF DERMATOLOGY AND HOSPITAL, HAMBURG, GERMANY.*

By M. F. ENGMAN, M. D., of St. Louis,

Lecturer on Dermatology and Syphilis, Marion-Sims College of Medicine; former Assistant to Dr. Unna, Hamburg.



PERHAPS I am safe in saying that Dr. Unna has established a school of dermatology distinct in many of its characteristic and original methods and ideas. He is not a follower of the older *Hebra dicta*, but has in many ways deviated from that school, and has established a new school, founded on diligent, conscientious and original research. Unna is the son of a Hamburg physician. One of his earliest works was on the anatomy of the skin, as published in the volume on *Diseases of the Skin*, in Ziemssen's *Cyclopædia of Medicine*, a masterful and exhaustive work, which he

completed in his twenty-fourth year. Since then the pages of dermatological literature have been enriched by many new and original ideas from his pen, his latest work being his *Histo-Pathology of the Skin*, a wonderful book of 1200 pages, devoted exclusively to the histo-pathology of the skin. When one looks at this immense volume and thinks of the amount of work that is entailed in its production, one is appalled; but when Unna has been visited, one can realize how such a work can be accomplished; namely, by clock-like work habits and a German's love for his work—his pleasure being his work, his work his pleasure.

Dr. Unna's "Klinik," or private hospital for diseases of the skin, is situated in Eimbutte, a suburb of Hamburg, and a beautiful suburb, too, with its pretty villas, its trees and flowers. The hospital and buildings are situated in a large, park-like grounds, consisting of a block or so, dotted with summer houses, shaded by big trees, under which cosily cluster tables, benches and chairs, speaking of cool glasses of beer and many a happy and pleasant hour for the patients or guests, even though covered with grease and bandages.

The hospital, or Elizabethan villa, named after Mrs. Unna, is the largest building, with accommodations for fifty patients. Another villa-like building is the laboratory, with rooms for students. This is complete with bacteriological, histological and pathological apparatus, and with shelves filled with pathological specimens. Dr. Unna's private dwelling is situated in the center of the grounds, and is a plain, home-like structure. A small cottage is for the use of families or those who wish to be more secluded.

It was my good fortune to remain for some time in this ideal place for

* Read before the St. Louis Academy of Medical and Surgical Sciences, September 28, 1897.

study, and to act while there as assistant, thereby gaining a greater insight into the practical methods for work.

Dr. Unna's hospital practice is, in fact, international, patients from every clime entering his clinic for treatment. While I was there Brazilians, Americans, Irishmen, Englishmen, Frenchmen, Russians, Germans—all were represented; presenting papules, vesicles and scales of all nations, whether from a Russian nobleman or a "free" American citizen, requiring alike a good, honest German lotion or grease; all coming under the treatment of the one—Unna. Like all Germans, Unna is very positive and, as we Americans would think, severe with his patients. They must submit to his treatment or go elsewhere; but as they generally soon see the wisdom of his way, they are anxious to submit.

His "rounds" are made at 7 A. M. and at 2 P. M., when he visits all his patients and orders their treatment. He is accompanied by his students at each visit, except in cases of ladies, where objection may be encountered. In the basement of his hospital are several rooms which are always filled with charity cases, where they receive treatment and board free. This is at Dr. Unna's own expense, and his kind heart gives them as much attention as his richest patients.

As this is a place where dermatology is taught and diseases treated as probably in no other place on the continent, or in the world, for that matter, it might be interesting to give a short sketch, first, of his methods of teaching; and, secondly, of his routine treatment for some of the diseases ordinarily encountered.

Most of the students that enter this school have a working or general idea of clinical dermatology; and it is much better for them to be thus advanced in both dermatology and histology, as then they are better qualified to understand and do the work required of them. A student, as soon as he has sufficiently declared himself and his abilities, is given some histological or pathological subject to work up; for instance, as he gave Monahemd Hodara acne and the bottle bacilli, or Eddowes, of London, Hexheimer's spirals. The subject, whatever it may be, is done under the Doctor's immediate supervision and advice. The student is allowed whatever latitude he desires or his energy and interest in his work demands. Many of his students have done excellent and original work, evolving new ideas and methods while with him. This Unna encourages, and his fertile brain often suggests to his student ideas in his special work which, when carried out and published, have given that student a name and rank in the scientific world, as Naber, Roberts, Von Duhring, Hodara, *et al.*



PORTRAIT OF DR. UNNA.

The practical part of the subject is not neglected. His hospital presents many cases for study, both therapeutical and pathological. The treatment and results are seen from day to day. The Jewish Hospital of Hamburg and a down-town clinic adds bountiful and varied clinical material for observation. Dr. Unna visits these clinics twice weekly with his students, and it reminds one of the days of the old Greek masters to see Unna surrounded on the car or walking to and from his clinics, probably all eagerly discussing some case just seen.

Dr. Unna is probably five feet eight inches in height, of a comfortable, rotund figure; a long, full, silky-brown beard falls over an always spotless shirt-front; his kind brown eyes look at one in a most bland and placid manner, but when awakened in anger they are as sharp and cold as steel. To his students he is fatherly and patient. His temper is even and unruffled. After the "rounds" in the morning, he spends a couple of hours in the laboratory, instructing his students, looking over, commenting on and advising them about their respective work. During his "rounds," at his clinic, in his laboratory, at any time, he may deliver a dissertation or talk (not a lecture) on some subject relative to dermatology. He requires of his students work, and would like them to be as he himself is—a devoted worker. He will not take a student for less than six months, but he prefers them to remain a year—long enough to do a couple of good studies and get into the proper system of study and research, in this way fitting them for further work in after life.

Below I will give a short *résumé* and general idea of his methods of treating some of the common diseases of the skin.

Eczema and Psoriasis.—The differentiation between these two affections is, at times very difficult. In the same individual we often see typical manifestations of the two diseases, shading one into the other—a convergence of form. That the two have a common cause, acting in different soils in different cases, and that cause being an organism, is thought by the Unna school. Dr. Unna's morrorcoccus, which he has demonstrated in the scales and horny layer of the epithelium, is thought by him to be the specific agent. But psoriasis as a name is retained to distinguish that form of disease so familiar to us all, characterized by flat, finely-scaly papules or plaques, usually well-marked on the elbows and knees. The same agent is found in both eczema and psoriasis; namely, the morrorcocci; and from the often striking convergence of form and appearance of the plaques or lesions, it is very probable that they are, as has been said before, of common origin. Anyway, both diseases are treated here virtually in the same general manner. Take, for instance, a general subacute or chronic eczema or psoriasis. The patient is first anointed with a mixture of green soap and oil, to soften the scales and render them easy of removal. This is allowed to stay on for a few hours; then he is placed in a hot bath and the scales gently removed, no friction being employed, so as not to injure the papillary layer and thereby cause an increased exudate or hemorrhage. After the bath his body and limbs are anointed with a salve of chryrsarobin $2\frac{1}{2}$ parts, ac. salicylic 1 part, ichthyol $2\frac{1}{2}$ parts, and vaseline 44 parts; the head, face and hands with an ointment the same as the above, with the substitution of pyrogallic acid for the chryrsarobin, as the latter is more irritating and will cause a severe con-

conjunctivitis if it comes in contact with the conjunctiva. These salves are applied twice daily, and the patient dresses in a loose union undergarment. This is continued for two or three days, when the patient will complain of the mild dermatitis caused by the ointments. They are then removed by the bath, and a paste of sulphur precipitate 10, oxide zinc 10, terra silicea 10, adeps lanæ 100, applied. The latter paste is very cooling and agreeable, and, with the addition of the daily bath, quickly lessens the irritation. Then the chrysarobin and pyrogallic salve are reapplied, as before, and the zinc and sulphur paste used when the dermatitis again occurs. After a couple of courses thus given the diseased plaques will be seen to whiten and disappear, while the surrounding healthy skin is dyed a yellowish-brown from the reducing agent. These courses are continued, and soon the skin becomes accustomed to the agent, until probably only a few small plaques or papules are left, remainders of the most indurated lesions.

These soon disappear under the application of chrysarobin in traumaticin, the mercurial plaster or the chrysarobin pencil. During the course the patient takes small doses of dilute muriatic acid, to neutralize the poisonous reducing effects of the agents on the blood, which is shown by symptoms of sick stomach, headache and greenish urine. The treatment lasts from three to five weeks, dependent upon the condition and resistance of the disease. If after the first or second course it is seen that the chrysarobin causes too much irritation, or is poisonous, tar is substituted, and at night a gown wrung out of 5 per cent. resorcin solution (aqueous) is worn, which softens the horny layer, and is itself parasitic. When through with the course of strong reducing agents the skin is found to be harsh and in parts scaly; but this condition is readily removed by the application of 2 per cent. to 3 per cent. resorcin in vaseline and at night the resorcin gown. All patients are given a parting warning to watch the scalp in future, to prevent a return of the disease, which is inoculated from the scalp in many cases. For this is used sulphur, salicylic acid or resorcin. In men, during the hospital course, the hair is cut short; in women, it is closely watched and treated. When a stubborn, resistant papule or plaque remains after all treatment, which is ordinarily overlooked, I have seen Unna cauterize them to be sure of their destruction and thereby probably prevent a recurrent attack which could occur from this nucleus of infection. In eczema and psoriasis a small spot is often overlooked, or, if seen, is thought to be insignificant, yet it probably provides material for a recurrence.

In acute and localized forms of eczema, other less radical means are used for its treatment, such as plaster mulls, salve mulls and various salves, lotions and varnishes. The salve mulls are salves made from different formulæ, spread on strips of muslin in such a manner that they can be applied to localized places of disease. They are made after Dr. Unna's formulæ, by Beiersdorf, of Hamburg, with a secret preparation of gutta-percha, and are an elegant and clean method of applying grease. They can be bought from Lehn & Fink, of New York. The plaster mulls are adherent to the skin, and are made in like manner of mercury, creosote, salicylic acid, etc., and are used in more indurated conditions, where stimulating and solvent effect is required.

As to diet, the patients are allowed to eat *ad lib.*, and food is bountifully provided for them. Internal treatment amounts to Fowler's solution in diseased conditions of the nails. "Belly washes" are not usually used in eczematous and psoriatic cases.

Rosacea.—There are two forms of rosacea: one that has a seborrhic tendency, situated on a base of dilated capillaries; the other has a tendency toward furunculosis, acne and comedones. In the former, the acute symptoms are reduced by mild lotions of ichthyol, or ichthyol and zinc salve mull. After the acute symptoms have subsided the horny layer is scaled off by a strong resorcin paste, the dilated capillaries being previously touched or traced out with Unna's micro-paquelin cautery. When the horny layer has been sufficiently thickened by the reducing agent, which takes from two to five days, the face is painted with zinc gelatin (formulæ given below) or covered with mild salve mull, and in from one to three days the thickened, horny layer comes off in large pieces, leaving a soft, pink skin underneath free from seborrhœa. In many cases the micro-paquelin is far superior to electrolysis; in fact, Unna uses it exclusively. It is superior to electrolysis in those cases especially where there is a diffuse redness or many small dilated capillaries. Besides directly obliterating the vessels, it causes a swelling of the collagenous material, and thus by pressure indirectly closes the vessels. After the scaling process a mild pomade of bismuth oxychlorate and oxide of zinc is daily applied, for its effect on the enlarged mouths of the follicles. Where there is much thickening and fibrous change, several scalings are necessary.

In cases of the second class, where there is furunculosis or pustular acne, a hydrarg.-carb. plaster mull is placed over the whole area or over each lesion. The plaster causes them soon to point at the apex or disappear through absorption of the inflammatory products. When the little lesions have pointed the pus is evacuated and the area is treated antiseptically, and when rendered clean is treated as the first class. Where there are furuncular complications, there is generally more thickening and superficial-fibrous change, requiring several scalings and several applications of the micro-paquelin.

But the remedy used as an adjunct to the above in all cases of rosacea, and the remedy *par excellence*, in my opinion, is ichthyol. It has an undoubted specific tonic effect on the blood-vessels, contracting them; regulates the bowels, having a general vascular tonic effect. The drug is given either in capsules or water, in doses of from five to ten drops three times daily.

The scalp here is also looked after to correct the seborrhic condition—an important element in the history.

Lupus Vulgaris.—In Europe one sees probably 75 per cent. more lupus than in America; and some of them are terrible and pitiful sights. One I remember in particular: a young girl of seventeen years. The disease had involved the head, neck, shoulders, and chest to about the third rib. The arms, here and there, and the hands presented serpiginous tubercular lines and nodules. On the legs were numerous circular patches. The face was terribly distorted by cicatricial contraction, and the scalp had lost most of its hair from the destruction of the follicles by the same process. The disease had begun on the face and extended gradually downward,

leaving little islands of lupus nodules and scales, cicatrizing as it progressed until a scaly tubercular ring had encircled the chest, completing a most horrible distorted picture. Here, lupus is treated as follows: If there is much acute inflammation and œdema, a mild ichthyol lotion is applied under a mask or bandage, getting the effects of pressure. When this has somewhat subsided, a salicylic-creosote plaster mull is applied daily until the nodules become softened and the granulomatous tissue is thrown off in small places, leaving little holes in the surface. Under the influence of cocaine each of these points are thoroughly bored out with a pencil or crayon of H_2Cl_2 , and a mild ichthyol lotion or salve applied. This is done daily for several days, and then the surface is allowed to heal under the salicylic-creosote plaster mull, or an ointment of chrysarobin. Special attention is paid to the nodules and scaly points, and whenever a soft, cheesy- or jelly-like mass is found it is bored out with the crayon. The whole surface is also washed daily with an antiseptic solution. The effect of pressure by bandage or mask is taken advantage of, thus preventing œdema, which is very dangerous in lupus, from the subsequent infiltration of the œdematous part with lupoid tissue. In all granulomatous growths of parasitic origin, œdema is dangerous; and any means that will prevent it will materially assist the treatment. The pressure should be uniform and even. I have seen brilliant results in Unna's clinic from the above treatment.

Acne.—True acne is that form of the disease which occurs at puberty with comedones about the face and shoulders, and with papules and pustules over the forehead and chin, also on other portions of the skin. Furunculosis is often mistaken for acne. Acne here is treated from a parasitic standpoint. The comedones are expressed and the pustules opened and treated antiseptically. Salves and pastes are used, containing either sublimate, salicylic acid, sulphur, resorcin, bismuth or combinations of the above. As a base a preparation made from peas is used, as it has the property of softening the horny concretions around the mouths of the follicles; allowing them to be easier expressed and the medicament to penetrate into the depths. Washing with Unna's over-fatted sublimate soap is recommended. The face is washed twice daily with the soap and the salve or paste applied, or a lotion of sublimate during the day and the unguent at night.

Abscesses and Furuncles.—In small abscesses and furuncles the following is an ideal method: If on a hairy part the surface is closely shaved and washed with ether to remove the grease. A piece of the hydrarg.-carb. plaster mull is applied, large enough to cover the whole surface. This is changed when it becomes loosened. Soon the tumor will begin to soften, and when fluctuation is detected a small opening is made in the lowest part and the pus very gently squeezed out. The plaster is reapplied and changed often, or washed off, which is more economical. There will be a constant and continuous flow of pus until the separation of the necrotic mass or "core." The surface is kept clean and the plaster applied until the cavity fills up, which it does very rapidly, leaving the smallest possible scar. Pain, strange to say, in the majority of cases, is relieved by the plaster, even before the relief of tension. The plaster seems to have a quickly resolvent effect and pus attraction. I have seen large abscesses in

the posterior cervical region cured, leaving an almost imperceptible scar, much smaller than that usually seen after the usual cutting operation. It is far superior, in some cases, to the modern surgical methods, in that it is by far less painful and the cosmetic results better.

Buboes.—Treated as above and often aborted.

Open Granulation Surfaces.—As after operation on the skin for rodent ulcers, epithelioma, curettings, etc., the wound is covered with salicylic-cresote plaster mull, which causes rapid healthy granulation, "bringing the epithelium from the depths," and resulting in a flat, smooth and pliable cicatrix, at the same time exerting a selective destructive effect on the pathological tissue.

Purpura and Echymoses (Black Eye).—Tr. arnica internally in large doses, with ichthyol externally in from 10 to 25 per cent. salve or lotion.

Varicose Ulcers.—To get pressure uniform, firm and constant from below upward is the principal factor in the treatment of varicose ulcers. This is fully obtained in the zinc gelatin bandage. Zinc gelatin is made as follows: Fifteen parts of gelatin is melted in forty-five parts water; fifteen parts oxide of zinc is rubbed up in twenty-five parts glycerine. The latter is added to the former, constantly stirring and thoroughly mixing. The mixture is poured into a crock or vessel and allowed to cool. When cool it is a firm, white elastic mass. When it is to be used it is melted by placing the vessel, in which it is contained, in hot water or in a pan of water placed over the fire. The gelatin should always be placed in water instead of directly over the fire to prevent its burning. When melted it is painted over the surface with a soft paint brush and allowed to dry. It makes an excellent varnish and protective in acute inflammatory conditions of the skin where there is not a profuse serous exudate.

The gelatin bandage is made by first painting the leg and foot with the gelatin, leaving the ulcers free for whatever application may be desired. A gauze bandage is used of usual leg width. Beginning at the instep the leg is snugly bandaged in the usual way to the knee, and the zinc gelatin painted over the whole. When nearly dry cover quickly with cotton, by rolling into a tight ball and dabbing quickly over the whole surface, thus leaving a thin film of cotton over the gelatin, which prevents it from sticking to the stocking. The bandage can be worn for a week or so, according to the condition of the ulcer. Unna treats the ulcer with stimulating and antiseptic salves or salve mulls and applies the bandage as above described. The dressing gives uniform pressure, is firm, yet elastic, and is a cheap and ideal dressing for varicose eczemas and ulcers.

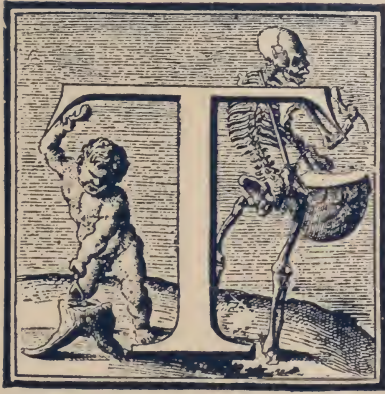
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A Strange Journal.—The *Medical Fortnightly*, which purports to be a St. Louis publication, is edited in Jacksonville, Ill., printed and mailed in St. Joseph, Mo., and is owned by a job printer—not by doctors, as has been supposed. This illegitimate sheet claims an "average guaranteed circulation of 8000 copies." We are in position to prove that, two years ago, it did not have 500 actual *bona fide* subscribers.

The same aforesaid job printer also owns the *Medical Herald* and the *American Medical Journalist*.

PHAGEDENIC CHANCROID.*

By A. H. OHMANN-DUMESNIL, St. Louis.



THE CHANCROID, soft chancre, "chancelle" of the French, *ulcus molle* of the Germans, non-specific chancre of many authors, is a lesion which has caused more mistakes by misinformed or poorly-posted physicians on the one hand and frauds on the other hand, by quacks, charlatans and unscrupulous physicians, than perhaps any other lesion of venereal origin. The term "soft" chancre has been the cause of more mistaken diagnoses than perhaps any other, except, possibly, the other one of "bubo." Any swelling in the

groin being a bubo, many imagine that the terms "multiple bubo" and "inguinal adenitis," employed by authors, are equally referable to a simple suppurating bubo, such as we generally find in chancroidal infection. The softness or hardness of a venereal sore is determined, in the first place, by the touch of the examiner; and it is here that much judgment and discrimination is to be exercised. Fear or hesitation may often lead to the erroneous supposition of hardness when such does not really exist. A simple infiltration is very apt to be taken for an induration by the careless or indifferently-posted investigator, and this sort of a mistake would certainly lead to very serious results, if not to positively disastrous ones, especially in a social way.

Again, the name "soft" is apt to lead to serious errors, from the fact that there are chancres which, under exceptional circumstances, are not accompanied by the induration, which is regarded as classic. I will not speak of the differential diagnosis of chancre and chancroid in this place, as I have already done so *in extenso* in a former paper in this series.† Suffice it to say that the physician should be certain in regard to the nature of the lesion which confronts him, and act accordingly for the greatest advantage of his patient. And I would advise, in case of doubt, the practice of auto-inoculations, which will be attended by the best and most indubitable evidence which it is possible to adduce under any circumstance, establishing a diagnosis beyond the possibility of a doubt, and thus adding to the certainty of the physician and, as a result, to the comfort of the patient. Make assurance doubly sure if you would gain the confidence of your patient, and always make your prognosis be borne out by subsequent developments. It is in this way only that any one can hope to establish a reputation and make his medical labors appreciated by

* Read before the St. Louis Academy of Medical and Surgical Sciences, October 12, 1897.

† TRI-STATE MEDICAL JOURNAL, January, 1896.

others and an honor to himself. Furthermore, it is in the field of venereal diseases that these requisites are more expected than in any other one.

Under ordinary circumstances the chancroid is an ordinary venereal lesion, which induces no very great inconvenience, yields rapidly to proper treatment, and is followed by a pretty rapid recovery, unaccompanied by any untoward symptoms or complications. The old method of treatment was, without doubt, an efficient one, but was looked upon by patients as worse than the disease. This procedure of applying strong cauterizing agents has been practically abandoned, to-day resort to them being only had in exceptional cases. The favorite applications were nitric acid, chromic acid, Ricord's paste, and stick nitrate of silver, all of which were excruciatingly painful. That they were efficient is beyond all doubt, but the inflammatory troubles which supervened were often of a most severe character. The fact that chancroid is caused by a micro-organism made such treatment efficient, if unpleasant. For this very same reason modern antiseptic treatment has proven of such value and is much less painful, and equally good, if not better, as it is followed by no disagreeable results due to the therapeutic agents employed. Modern microscopic investigation has certainly done much to ameliorate matters in this respect, as it has done in many other instances. But it is not my purpose to refer to the peculiar clinical characteristics of chancroid, its treatment, complications, and other facts observed in connection with this peculiar process. One fact to which I desire to call attention, however, is that in the ordinary form there is, perhaps, no agent superior to iodoformin, which is practically odorless and does not irritate. It, however, releases nascent iodine gradually, and this has the property of not only destroying the micro-organism, but of stimulating the affected tissues just sufficiently to bring on healthy granulation and a rapid *restitutio ad integrum*.

The object of these remarks is not to dwell upon the chancroid in its classic form, but rather upon a form which is of the highest interest as well as importance. It is a well-known fact that occasionally the chancroid takes on a rapid and serious destructive action, whereby the tissues suffer to an alarming extent. They are, in a manner, eaten up, which has given rise to the terms phagedena and phagedenic. There is no doubt that the cause of this peculiar condition is one referable to a mixed infection. The presence of the staphylococcus or of the streptococcus and staphylococcus combined, will lead to the inception of this peculiar process. The same conditions are observed in other lesions, such as the chancre, syphilitic ulcers, etc. It is at all times a most destructive process, and one which absolutely requires very radical measures. It is, perhaps, most fortunate that it is of comparatively infrequent occurrence; but its possible presence is one of the strongest arguments to physicians of the necessity of not looking upon chancroids as merely very simple lesions, and of the absolute necessity of keeping a watchful eye upon every case, in order to be able to arrest any phagedena, should there occur any sign whatever that it is about to declare itself. This is necessary, not only for the prevention of destruction of the most marked character, but to avoid the complete loss of the life of the individual, as has happened in some cases. That such marked symptoms or lethal outcome is not more com-

mon than usually observed, is dependent upon a number of circumstances which will be detailed as the consideration of the subject is taken up.

It would appear, however, that among the conditions which are nearly always present, and which would seem to act as predisposing factors, may be noted a depraved general condition. Associated with this may be found a state of poor nutrition and more or less malassimilation. Joined to this, and the most important factor, is greater or less inattention to cleanliness, which leads to the easy infection by and growth of the micro-organisms which have been mentioned above. It is also to be noted that, when a chancroid exists, inattention to the lesion or inefficient treatment may also aid, not only in its spread, but in the inception of a marked destructive process which easily converts itself into phagedena. On the other hand, the best of treatment will not prevent the occurrence and development of the latter, unless heroic measures be adopted and pursued. It acts very much in the manner of hospital gangrene, under certain conditions. For it has a tendency to attack several individuals affected with chancroid, if they happen to be in comparatively close proximity, such as in a hospital ward. One case will develop phagedena and the infection spreads to the others, implicating all in a very short time. This is another reason to exercise watchfulness and care in the treatment of chancroids, for a little attention will enable the physician to recognize a possibly dangerous case and segregate it before the infection can spread, and thus avert much suffering, destruction of tissue and consequent deformity, not to mention a large number of untoward symptoms. The fact alone, without microscopic investigation to confirm it, that phagedena can spread itself in a hospital ward to other cases of chancroid is certainly proof sufficient that it is due to micro-organisms acting in the same manner as the same factors do in all infective processes. The researches of investigators and of bacteriologists have also demonstrated this, so that it may be now accepted as an established fact.

The phagedena in chancroid is fulgurating in character. It acts with almost lightning-like rapidity in some cases, and it is singularly destructive in character. A reference to the medical history of the Mexican War, when the American troops were in a poor physical condition, will reveal numerous records of such cases. The phagedena was so virulent that gangrene set in almost immediately, and was followed by a loss of a part or of the entire penis. It was universally dreaded, and came to be known under the soubriquet of the "black lion." Many thought, as they do now, that both the Mexican and the Chinese "pox" were of a worse character than the same disease in other nations or races. But the climatic and hygienic conditions, no doubt, had more influence than any other causes. But to return to the phagedenic chancroid. The process, whilst destructive, does not follow any regular course. It has a tendency to assume a serpiginous form, and markedly undermines the tissues. This leaves the edges of the integument overhanging, the skin being more refractory to the destruction than its underlying tissues, and there is constantly present a most excruciating pain. There seems to be no limit to its ravages, if permitted to go on unchecked. Several years ago I had the opportunity of seeing one of the most markedly destructive cases which has ever been recorded. The patient, a young man, contracted what appeared to be an

ordinary chancroid. Worn by dissipation, rather anemic and thin, he was not in a condition to neglect the lesion as he did. As a result of this carelessness and inattention on his part, phagedena soon set in and spread with frightful rapidity. It did not limit itself to the external parts, but made its way into the urethra and thence to the bladder. The sufferings undergone by the patient are simply indescribable. In about a week he was dead, and a *post-mortem* examination showed that there had been perforation of the bladder of very recent date, as a peritonitis had not established itself. Such cases are certainly rare, but are illustrative of the serious nature which phagedenic chancroid may assume under circumstances favorable to the process. They further show the absolute and great danger which may attend an apparently simple sore which is neglected. The most extensive chancroid, phagedenic in character, which I have ever seen, was one in a negro which involved the entire abdomen and the thighs. He was a hospital patient and was fortunate enough to be cured, at the cost of much



FIG. 1. Multiple Chancroids—Phagedena beginning.

suffering and the loss of nearly all of the skin which was implicated. A portion of the integument was replaced by skin grafts, the remainder cicatrizing.

The appearance of a phagedenic chancroid is clearly indicative of the condition present. The affected area has a worm-eaten floor, the destruction is deep, and the edges are undermined. In Figure 1 is given a picture of multiple chancroids beginning to take on a phagedenic character. The edges of the lesions are still somewhat regular in form, and there can already be seen evidence of the tendency of the lesions to join one another, the intervening bridge of sound tissue breaking down and ulcerating. The patient in this case made a comparatively rapid recovery, as the destruction had not yet become extensive or very deep. The trouble being comparatively in its inceptive stage, there was but little difficulty experienced in jugulating it. In some cases the tissues look not only worm-eaten, but as if a rat had gnawed off certain portions, and the appearance

presented is a hideous one. Thus, in Figure 2 is shown a case in which the penis looked as if it had been run over by a wagon-wheel. The posterior surface of the organ was involved from the perineum to the glans, which had remained intact. The tissues were destroyed extensively, although the urethra was spared. The phagedenic process was plainly apparent, large shreds of dead, suppurating, and even putrefying, tissue existing. The whole surface looked ragged and bled at the slightest touch. The destroyed surface was about three inches in width at its broadest part. The general increase in size can best be judged by a reference to the illustration. The appearance of the affected surface can also be seen and the amount of destruction noted. Yet, notwithstanding the deplorable condition which existed, a rapid improvement manifested itself directly after the phagedenic surface had been thoroughly cauterized with fuming nitric acid. A subsequent iodoform and gauze dressing acted so well that the patient left the City Hospital, where he had been treated, before the trouble



FIG. 2. Extensive Phagedenic Chancroid of Penis.

was entirely healed. His subsequent history is unknown to me, but there is no doubt that the healing process which had well progressed continued without any further incident.

When phagedenic chancroid attacks a woman the destruction is always greater than in a man, owing to the fact that a much larger surface is presented by the external genitalia. It is not unusual for the labia minora and clitoris to be destroyed, the labia majora also suffering severely. In Figure 3 may be seen a picture of a case in which both labia minora, the right labium majus and the clitoris were destroyed. The encroachment of the process on the right buttock is also plainly seen, as well as the isolated patches of destruction separated from the main phagedena. It is not at all unusual for the phagedenic process to encroach upon the vagina, and subsequently lead to a greater or less atresia or stricture, caused by reparative cicatrization. In the case shown in Figure 3 there existed a foul,

sanious secretion of ill-smelling pus, considerable in quantity and of a highly corrosive character. Throughout the pus shreds of disintegrated tissue could be observed.

The treatment of phagedenic chancroid is one which needs more than ordinary care and attention, as has already been said above. The first



FIG. 3. Extensive Phagedenic Chancroid of Vulva.

thing to do is to give the ulcerated surface a thorough cleansing by means of a warm solution of some antiseptic. The strength need not be particularly marked, as the object is to obtain, as far as is possible, a comparatively clean field to work on. If the surface be extensive and offer a comparatively large area, as in the cases shown in Figures 2 and 3, the patient should be anesthetized, as the pain of the subsequent operation is such as to

be unbearable without recourse to general anesthesia. Cocaine is impotent in such an instance, as it does not penetrate to a sufficient depth; and the infiltration method is more tedious than administering an anesthetic. The operation consists in curetting the ulcerated surface, in order to remove all the destroyed and partially-destroyed tissues. Of course, it is not necessary to resort to this measure in every case, as some can be very well treated, when the destruction has not become too deep, without having recourse to surgical procedures. In either case, the next step in the treatment is the application of fuming nitric acid to the implicated tissues. This should be made as thorough as possible, to avoid the necessity of a subsequent application. The final step is the application of some antiseptic ointment or powder and a proper dressing. An ointment is preferable to a powder, because it will not adhere to the wounded surface and permits of a clearer view of the field being had. A good ointment for this purpose is the following:

℞ Pulv. Campho-phénique..... ʒj
 Ung. Aquæ Rosæ..... ʒiv
 M. Sig.—Apply twice a day.

A good adjuvant to this is the use of peroxide of hydrogen before each dressing is made. It is a good pus destroyer and has the property of searching out any purulent collection wherever situated. It also possesses the property of destroying the phagedenic tendency by its action on the micro-organisms which are the cause of it.

At each dressing the utmost vigilance should be exercised to discover any possible point which might have escaped, as this would form a new focus to cause a recurrence and foster further extension of the phagedena. Generally, under proper treatment, the healing process is at best but a slow one; still, it is progressive—and the duration is entirely dependent upon how early the trouble was recognized and how energetically it has been treated. Overtreatment is to be avoided, as it may prove a source of irritation instead of the contrary. One thing which is to be avoided in the treatment of phagedenic chancroid is the use of iodoform. Whilst this remedy is excellent in ordinary forms of chancroid, it does not seem to exert any but a deleterious action in the malignant or phagedenic form. At best, under the most skillful treatment, no bright hopes can be held out to patients. The process can be arrested and a cure effected, but deformity cannot be prevented, and, in most instances, cannot be repaired.

Health in Chicago.—During September the total deaths in Chicago were 1,679 or 1.04 per 1,000, as compared to 1.02 per 1,000 for the same period in 1896. Of these, 464 were under one year of age, 219 between one and five years. The leading causes were: Diseases of nervous system, 203; consumption, 175; infantile diarrhœa, 152; other acute intestinal diseases, 163; heart diseases, 92; cancer, 76; pneumonia, 67; diphtheria and membranous croup, 53; typhoid fever, 48; bronchitis, 37.—*The Journal.*

FORMULÆ.

Malaria.—First, if there is a chill, I at once administer one-half to one drachm of chloroform, to warm up the patient. Then I give the following: For the fever, antipyrin, gr. x, to get up a sweat. After this is established I give:

℞ Hydrarg. chlor. mit..... gr. x
Pulv. rhei..... gr. ij
Pulv. cretæ aromat..... gr. iv
Sodii bicarb..... gr. x

M., pulvis No. 2. Sig.—One every four hours, followed with salts if there is no action in four hours after last powder.

℞ Quinia sulph..... ʒ j
Acid. hydrobromic dil..... q. s
Aq. pura..... ʒ ij
Syr. toltan..... ʒ ij

M. Sig.—Teaspoonful every two hours until next expected attack.

TONIC.

℞ Tinct. ferri mur..... ʒ iss
Quinia sulph..... ʒ ss
Syr. simplex..... ʒ vj

M. Sig.—Teaspoonful three times daily after meals.

In conclusion, I will say again that this is not written to get up gastric disturbances among the profession, but to show my experience in the use of the drug quinine; and since antikamnia has come to stay I use them both in combination, and find I can do much good in the treatment of malarial fevers, etc. I am a believer in remedies that give results, and I have never been disappointed in the above.—*Carrington, Med. Summary.*

Ointment for Pruritus.

℞ Mentholi..... ʒ j
Cerat. simplicis..... ʒ ij
Ol. amygdal dulcis..... ʒ j
Ac. carbolicæ..... ʒ j
Pulv. zinci oxidi..... ʒ ij

M. Sig.—Apply morning, noon and night, after cleaning the parts.—*Kelsey, Ex.*

Vaginitis.

℞ Pulv.....
Aluminis.....
Zinci sulphatis.....
Sodii biboratis.....
Acidi carbolicæ..... aa ʒ j
Aque..... ʒ vj

M. Sig.—A tablespoonful to a quart of lukewarm water as a vaginal injection twice daily.—*Vanderbilt Clinic.*

Formula for Extract of Felix Mas in Children.

℞ Ext. filicis mar. eth..... 4
Calomel..... 0.4
Aq. dest.....
Sacch. alb..... aa 15
Gelatin, q. s.....

℞ Ext. filicis mar. eth.....
Tinct. vanilla..... aa 3
Syr. terebinth.....
Aq. dest..... aa 25
Gum arabici pulv..... 2

M. Sig.—One dose to be taken in milk.—*Pediatrics.*

Ichthyol in Scrofulus Blepharitis and Keratitis.—Sehlen (*Clinique ophthalmique, Therapeutische Wochenschrift*), recommends the following ointment:

℞ Ichthyol..... part j
Powd. Starch.....
Zinc oxide..... aa parts xx
Vaseline..... parts 50

M. To be applied to the edges of the lids at night and morning.—*N. Y. Med. Jour.*

Acute Bronchitis.

℞ Ammon. muriate..... gr. 80
Tartar emetic..... gr. j
Iodide potass..... gr. xvj
Simple elixir..... ʒ iv
Aq. dest., q. s. ad..... ʒ viij

M. Sig.—A tablespoonful every three or four hours.

The above will afford quick relief to the congested mucous membrane of the bronchial tubes, and rapidly establish mucous secretion.—*Texas Med. Jour.*

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EXPERT TESTIMONY.

The profession has no cause to be ashamed of the learned testimony exhibited by the experts in the celebrated Luetgert case, recently tried in the city of Chicago. Unless I am greatly mistaken in the outlook, the fact has been again demonstrated that circumstantial evidence is as much superior to human testimony as the perfection of nature is superior to works of art. It has been again shown that no event, however important or trifling, can take place on this earth without leaving its perceptible and unerring foot-prints by which it may be traced.

The Luetgert Case. Daniel Webster once remarked: "The whole creation of God holds neither nook nor corner where the unhappy murderer can hide his awful secret and say it is safe." In the Luetgert trial, in spite of a penumbria of medical experts, so-called, who knew but little or pretended to information which they did not possess, the great perfection of anatomical knowledge shines forth almost without a flaw. From a few sesamoid bones and a few phalanges, the body of a woman was reconstructed; and from a few metallic ornaments and a few shreds of cloth was proved, to the satisfaction of nearly everybody concerned, the identity of that woman. Many may think that such knowledge is beyond the mind of man; but the fact remains, that while it is

rare, it is not unknown in the past. Many years ago, when the great Agassiz, now dead, was but a lad, he applied for membership in a Royal Scientific Society. Some of the long-beards asked him what he knew about science; he replied that he thought he knew something about fishes. They handed him a single fossil scale that had been broken out of a piece of rock, deposited in a distant geological era. He took the scale, examined it carefully, went to the blackboard and drew the picture of a strange and wonderful fish of which nobody had ever seen or heard. Some time after, the geologist working in the same strata came upon the complete fossil of a fish. He had it carefully removed and carried up to the rooms of the society and compared with the drawing which Agassiz had made. They were found identical. Time after time, but never before in courts of law, have naturalists reconstructed an entire animal from a single bone. The courts will some time discover that the laws by which animal morphology is governed are far more strict and unvarying than any human statutes promulgated by king, prince or potentate, or even the wisdom of senates.

Those whose scientific knowledge is limited can hardly comprehend the great advances which have been made in the study of natural history. The newspapers are swift to herald some great fake, who pretends to have discovered some method of manufacturing gold out of lead, or inventing some new remedy for a hitherto incurable disease, but the careful plodding work of the deserving obtains but few of the bugle-notes of praise. The true scientist wins little enthusiasm; his fellow-scientists are prone to be envious and have a tendency to minimize his work, and there is no excitement for the laity in any discovery that amounts to so little in a financial way to the discoverer or any one else. A little gold on the Klondike is of much more importance to them than the translation of the Rig-Veda or the restoration of the Megatherium. But, in spite of all these discouragements, the good work goes on, often *sub rosa* while the worker labors in some menial occupation for his daily bread. But once in a lifetime, or maybe not all, there comes to him the opportunity, as in the Luetgert case, to demonstrate to the world what he can do. It is then that his industry and learning is recognized and reluctantly admitted, while the pretense of the fake is exposed and shown up at its true value.

There is nothing in fiction or drama more pleasant to witness than the triumph of "Puddin'-head Wilson," as it was portrayed on the stage by the late Frank Mayo. Laughed at and sneered at by his neighbors for his little fad of taking the impressions of people's thumbs on slips of glass, looked upon as a sort of mild lunatic, he lived and studied until at last, in a court of law, he showed himself able to identify each and every member of the community by the marks of their thumbs.

When Professor Webster attempted to destroy the body of the murdered Dr. Parkman, he worked for nearly three days in his laboratory, but in the ashes of the grate there was found a small piece of an upper jaw-bone, to which a few teeth were attached. Not only were these recognized as human teeth, but the dentist who had filled them was able to identify them as the teeth of the late Dr. Parkman, and thereby was constructed the *corpus delicti* so necessary in a well-conducted murder trial.

The marks by which a man is recognized by his friends are very deceptive—

“Danger, long travel, want and woe
 Will change the forms that best we know;
 And deadly fear will time outgo
 And blanch, at once, the hair.
 Hard toil will roughen hand and face,
 And hunger quench the eyes' bright grace;
 Nor can old age one wrinkle trace,
 More deeply than despair.”

Many a time and oft in the city morgue has a dead body been recognized by two or three different women and claimed as the remains of a dear, departed husband; and, perhaps, occasionally with some degree of truth in each case, for some of the ways of men are past finding out.

The real evidences of identity are those marks which never change: such as the measurement of the bones, congenital and acquired deformities, scars of wounds, voice, gait, manner, shape of head, nose, ears, etc.; the color of eyes, the shape and condition of teeth, and the minute markings on the palmar surface of the hands.

Detective work of this character requires wide knowledge and special knowledge, but most of all a natural aptitude which enables a man to trace effects back to causes. Many people can reason from cause to effect, but few are able to reverse the process. Expert testimony can be bought. Opinion testimony is worthless and is fast reaching the position which it deserves in the estimation of courts and juries, but the value of the learned witness in the development of facts in a law case, properly explaining them and pointing out their true importance, is and always will be inestimable.

R. C. B.

SCHERING'S FORMALIN LAMP.

We would respectfully direct our readers' attention to the advertisement of Messrs. Schering & Glatz, of 55 Maiden Lane, New York. This reliable firm is manufacturing a lamp for the use of formalin as a disinfectant and deodorizer. It is a perfected and most convenient apparatus, in which dry formalin (paraform) pastils, containing 100 per cent. pure formaldehyde, are vaporized over an alcohol flame. It is unsurpassed in effectiveness and simplicity. Such an apparatus is a necessity.

GUIDE TO CLINICAL AND LABORATORY INSTRUCTION IN ST. LOUIS. FOR GRADUATES IN MEDICINE.

Physicians who desire to see clinical work are respectfully informed that they will be admitted to the clinics held by the gentlemen whose names are given below.

Laboratory Instruction for Practitioners of Medicine is given by Dr. James A. Close, 2031 Olive street. The course includes Clinical Chemistry, Bacteriology, and Pathology.

As soon as we are informed thereof, we will print the hours of other clinics. Probably by another month we will be able to present a schedule much more extensive than the following:

Hour	9 to 10	10 to 11	11 to 12	12 to 1	1 to 2	2 to 3	3 to 4	4.00 to 5.30
MONDAY		DR. W. A. MCCANDLESS, <i>Surgery</i> , St. Mary's Infirmary.	DR. OTTO SUTTER, <i>Surgery</i> , City Hospital.			DR. F. J. LUTZ, <i>Surgery</i> , Alexian Brothers' Hospital.		DR. HUGO SUMMA, <i>Pathological Demonstrations</i> , City Hospital.
TUESDAY	DR. POLLOCK, <i>Ophthalmology</i> , Mullamphy Hospital.	DR. OHMANN-DUMESNIL, <i>Dermatology</i> , City Hospital.	DR. G. F. HULBERT, <i>Gynecology</i> , Woman's Hospital.	DR. F. C. EWING, <i>Ear, Nose and Throat</i> , City Hospital.	DR. A. E. MINK, <i>Neurology</i> , City Hospital.	DR. F. E. FURNEY, <i>Internal Medicine</i> , City Hospital.	DR. WALDO BRIGGS, <i>Surgery</i> , City Hospital.	
WEDNESDAY			DR. OTTO SUTTER, <i>Surgery</i> , City Hospital.					
THURSDAY	DR. POLLOCK, <i>Ophthalmology</i> , Mullamphy Hospital.				DR. F. C. EWING, <i>Ear, Nose and Throat</i> , City Hospital.	DR. PUSKENEY, <i>Surgery</i> , City Hospital.	DR. C. M. PHILLIPS, <i>Gynecology</i> , <i>Surgery</i> , City Hospital.	4.15 to 5.30 DR. HUGO SUMMA, <i>Pathological Demonstrations</i> , City Hospital.
	DR. A. C. BERNAYS, <i>Surgery</i> , Woman's Hospital.							
FRIDAY			DR. G. F. HULBERT, <i>Gynecology</i> , Woman's Hospital.			DR. SUMMA OR DR. CRANDALL, <i>Internal Medicine</i> , City Hospital.	DR. A. H. MESSERBACH, <i>Surgery</i> , City Hospital.	DR. A. M. CARPENTER, <i>Internal Medicine</i> , City Hospital.
							DR. PUSKENEY, <i>Surgery</i> , Woman's Hospital.	
SATURDAY	DR. POLLOCK, <i>Ophthalmology</i> , Mullamphy Hospital.		DR. OTTO SUTTER, <i>Surgery</i> , City Hospital.				2 to 4 DR. JAMES MOORES BALL, <i>Ophthalmology</i> , Woman's Hospital.	
	DR. EMORY LANPHEAR, <i>Surgery</i> , Woman's Hospital.							3.30 to 4.30 DR. KEBER on <i>Syphilis</i> , or DR. ATWOOD on <i>Venereal</i> , City Hospital.

NOTE.—Clinics held in medical college buildings, and in hospitals adjoining them, have been omitted for good reasons.

THE EXHIBITS AT THE LOUISVILLE MEETING.

Robinson-Pettet Company.—This well-known firm had a fine display under the charge of Mr. Lou A. Beckham. Their establishment at 528-532 West Main street contains one of the best drug stocks in the Mississippi Valley. Their pharmaceutical specialties are well known to physicians and are extensively used.

The Geyser Hot Appliance.—Mr. Arthur S. Winslow, of New York, was in charge of this exhibit and was kept busy answering inquiries. The Hot Appliances are neat, clean and are admirably adapted for the treatment of all diseases requiring hot applications.

White Rock Ozonate Lithia Water.—The genial and hustling Mr. F. C. Parker, of Quincy, Ill., was on hand to represent this famous lithia water. This booth was always crowded and the doctors must have consumed an enormous quantity of "White Rock."

Clark & Roberts.—This Indianapolis firm was represented by Mr. R. B. Roberts and Mr. S. T. Henderson. They displayed a chair, a table and a new instrument cabinet which is as fine a specimen of elegant workmanship as we have ever seen. The cabinet possesses a combination lock and is a fine article of furniture.

The Fessenden Manufacturing Co.—This is a prominent Pittsburgh Company which is manufacturing a superior X-ray machine. They have adopted the use of the induction coil in preference to the static machine, or so-called Tesla coil. The apparatus was in charge of Mr. E. S. Lea.

Tarrant & Co.—Mr. John S. Allen represented the Tarrant preparations.

Dios Chemical Co.—Dr. A. W. Latimer was in charge of a fine booth devoted to the preparations of the Dios Chemical Co., of St. Louis.

Fries Bros.—Kelene, pure chloride of ethyl, is a specialty of the Messrs. Fries Bros., 92 Reade street, N. Y. We noticed that many physicians were interested in this exhibit. Their Formaldehyde Generator attracted great attention.

The Pyroctin Co.—Dr. T. F. Bray was in charge of the exhibit of the Pyroctin Co., of Columbia, S. C. This is a new preparation which is said to be very valuable.

Wm. H. Armstrong & Co.—The Armstrong house is one of the well-known Indianapolis firms. It was represented by Mr. C. H. Dinkelaker.

The Globe Manufacturing Co.—This company makes high-grade medical apparatus for diseases of the nose, throat and lungs. It was represented by Mr. W. L. Root.

Benzoinol Manufacturing Co.—Benzoinol was represented by Mr. John M. Tobin. His booth presented an attractive appearance.

Fairchild Bros. & Foster.—These manufacturers of standard remedies were on hand with two of their most popular representatives: Messrs. O. W. Schmidt and W. C. Church.

McKesson & Robbins.—Dr. Evans and A. V. Hennicke were present and left a favorable impression with the attending physicians. The preparations made by this firm are well known to the profession.

Henry K. Wampole & Co.—Dr. L. H. Warner and several assistants

were kept busy attending to the wants of the physicians visiting this booth. Their goods were displayed to good advantage.

Sharp & Dohme.—The display of Messrs. Sharp & Dohme was under the charge of Mr. Frank N. Pike, one of the most popular men in the West. Anything that Pike says is true.

Seabury & Johnson.—One of the largest and finest of the displays was that of Messrs. Seabury & Johnson. It was under the direction of Messrs. J. B. Davis and C. L. Henry.

The Carter Manufacturing Co.—This is a Louisville firm which is getting into prominence, owing to the excellent quality of its goods. Any kind of electro-therapeutical apparatus can be obtained from them. Their display was at 258 West Main street.

C. Bischoff & Co.—Dr. P. Caspers was in charge of an exhibit by Messrs. C. Bischoff & Co., of 87-89 Park Place, N. Y.

J. J. Elwood Lee Co.—This firm, of Conshohocken, Pa., had a huge display of gauze, bandages, catgut, etc. They are among the largest manufacturers in the world. This booth was under the charge of Dr. H. L. Mann.

American Biscuit & Mfg. Co.—Mr. J. E. Lewis represented Somatose Biscuit.

"Tri-State Medical Journal and Practitioner."—This JOURNAL occupied a prominent booth, which was under the charge of Miss Katie Hegel. Many new subscribers were secured at this meeting.

Parke, Davis & Co.—This splendid firm was ably represented by four of its best men: Fred. J. Carter, of St. Louis; Louis C. Layson, Cyrus A. Smith and Jokichi Takamine. They were engaged in explaining the merits of the preparations for which this firm has gained a world-wide reputation.

R. F. Balke & Co.—Louisville is noted for its fast horses, good whiskey and beautiful women. There is no better whiskey made anywhere than by Messrs. R. F. Balke & Co. Runnymede Club Whiskey was sampled and pronounced good. Mr. Buchanan, of St. Louis, was in charge.

Jesse Moore, Hunt Co.—This firm did not make a formal display, but, nevertheless, many physicians were invited to sample their bottled goods, which are everywhere noted for purity. Their AA Whiskey commands a large sale.

Wm. R. Warner & Co.—This firm always makes a creditable showing, and the Louisville meeting was no exception to the rule. The Warner booth was one of the busiest places in the exhibit hall.

Frederick Stearns & Co.—A good display was made by this house.

Drever Manufacturing Co.—Mr. Berry presided over the display of Marchand's preparations.

Horlick's Food.—A suitable booth was occupied by this standard food. Dr. S. Z. Bryson and Messrs. Alexander Horlick, Charles M. Phelps and Joseph Lister were in charge. Horlick's Food has met with a remarkable sale.

Doliber-Goodale Co.—Mellin's Food is probably known to every doctor in this country. The exhibit was under the management of Dr. Austin D. Smith and Messrs. T. I. Delano and J. B. Larrabee.

Schieffelin & Co.—Mr. J. E. Lewis represented this old and reliable house. The Schieffelins always make an interesting exhibit.

Londonderry Lithia Water.—The Louisville representative was on hand and gave out Londonderry Water with a lavish hand.

Arthur Peter & Co.—This Louisville firm was represented in a fitting manner.

KENTUCKY'S GOVERNOR.

The medical profession of Kentucky is deservedly proud of Governor Bradley. He is the foe of charlatanism. In extending a welcome to the members of the Mississippi Valley Medical Association, he said:

“Kentucky and the city of Louisville desire to honor themselves by honoring you. You are ornaments to the profession—one of the grandest known to men.”

He believed that the day of the quack had passed and that, as far as the medical profession was concerned, Kentucky could make as respectable a showing as any State in the Union. He spoke of the immense strides made by the profession, believing that in its medical remedies and surgical operations it had reached nearer the topmost round of all that could be achieved than any other profession.

“There is only one thing a physician can not do,” said the Governor. “He can't give a man brains, for if he could he would have placed some in the heads of certain Indiana people and kept them from quarantining against Louisville.”

In concluding, Governor Bradley said that the occasion was not only one for the interchange of ideas, but that it was also a season of good-will and jollity, and so he welcomed the visitors to that good old-fashioned hospitality which Kentuckians pledge can be found in no other spot on earth outside of their own State.

POWER OF THE MEDICAL PRESS FOR GOOD.

Few of us realize the power of the medical press to make or mar a cause. Recently the Iowa College of Physicians and Surgeons, located in Des Moines, has had a valuable object-lesson in this respect. The college never has been above criticism. Last winter it was demonstrated that respectable women in the class were insulted by male members, that vile and vulgar prescriptions were placed in full sight of the students, that the final examination was a farce, that there was a woful lack of discipline, and that the Medical Department of Drake University was little better than a diploma mill. This was the school in which ethical (?) men were teaching. Evidence of a damning character was printed in the *Iowa Medical Journal* and the *TRI-STATE MEDICAL JOURNAL AND PRACTITIONER*. What was the result? Last year the school had nearly one hundred students. This year it has less than fifty. Perhaps in another year it will be “ausgespielt.”

The Iowa profession is all right. It has no use for fraud, hypocrisy, deceit or vulgarity.

ACADEMICAL NOTES.

The St. Louis Academy of Medical and Surgical Sciences met September 28th, and listened to a paper by Dr. M. F. Engman, Lecturer on Dermatology in the Marion-Sims College of Medicine. The paper is printed elsewhere in this month's JOURNAL.

No meeting was held October 5th, owing to the visit of the Veiled Prophet.

At the meeting of October 12th, Dr. A. H. Ohmann-Dumesnil read a paper entitled "Phagedenic Chancroid." Dr. Hugo Summa, by request, demonstrated some pathological specimens obtained at the City Hospital. Dr. George F. Hulbert presented an interesting specimen.

The application of Dr. Engman was voted on and he was elected to fellowship.



About Children.—Six Lectures given to the Nurses in the Training School of the Cleveland General Hospital, in February, 1896. By SAMUEL W. KELLY, M. D., Professor of Diseases of Children in the Cleveland College of Physicians and Surgeons. Octavo, pp. 179. Cleveland: Medical Gazette Publishing Co., 1897.

Although delivered to nurses, this little book contains much of practical value to the physician. The lectures have been prepared with great care and are models of clearness. The reader will not be in doubt as to the author's meaning. We expect a large sale for Dr. Kelly's book.

Typhoid Fever and Its Abortive Treatment.—By JOHN ELIOT WOODBRIDGE, M. D. Second Edition. Octavo, pp. 368. Cleveland: 1896.

The author has been prominently before the profession for several years as an advocate of the "abortive" treatment of typhoid fever. The author says: "The book has been written in defiance of the opinions of the bacteriologist, who has demonstrated the impossibility of destroying the bacillus typhosus in living man; of the pathologist, who has shown that the micro-organism finds its way deep into all the organs of the body, and hence can not be dislodged; of the therapist, who has asserted that drugs can accomplish no useful purpose in the treatment of typhoid fever; and of the theorist, who has exposed the ignorance of those who believe in the curability of the disease."

Such statements are worthy of a conscientious, enthusiastic clinician

and discoverer; and such we believe Dr. Woodbridge to be. We ask those who do not agree with the doctor should read his book. The time will not be wasted.

Surgery of the Rectum and Pelvis.—By CHARLES B. KELSEY, A. M., M. D., Professor of Surgery at the New York Post-Graduate Medical School and Hospital. With 281 Illustrations and half-tone plates. Imperial octavo, pp. xviii.—573. New York: Richard Kettles & Co., No. 129 Fifth avenue, 1897.

This is a work of the greatest value, not alone to the proctologist and the pelvic surgeon, but also to the general surgeon and the general practitioner. The wisdom of combining the diseases of the rectum with those of the pelvis is apparent. The volume begins with an excellent chapter on the anatomy of the parts, followed by a lucid description of methods of examination and general rules regarding operations. Then come chapters on congenital malformations, proctitis and periproctitis, abscess, pelvic abscess in women, fistula, hemorrhoids, prolapse, intussusception, non-malignant growths of rectum and anus, non-malignant ulceration, venereal diseases of rectum and anus, non-malignant stricture of rectum, cancer, Kraske's excision of the rectum, formation and closure of artificial anus, intestinal resection and anastomosis, etc., etc. The work is one which commands the admiration of the reviewer. Many of the illustrations are original. The publishers have done their part well. We predict an extensive sale for this excellent treatise.

Lectures on the Malarial Fevers.—By WILLIAM SYDNEY THAYER, M. D., Associate Professor of Medicine in the Johns Hopkins University. With Nineteen Temperature Charts and Three Lithographic Plates showing the Parasite of Tertian, Quotidian, and Æstivo-Autumnal Fevers. Small 8vo., 326 pages. Cloth, \$3.00.

This is the only work in the English language which contains a full record and exposition of the subject of malaria. These lectures were delivered before the post-graduate class at the Johns Hopkins Hospital, and consist of a summary of the present status of our knowledge concerning malarial fevers. The author describes the method of blood examination, the hæmocytozoa of malaria, and names the general conditions under which the malarial fevers prevail. He gives a clinical description of the fevers, their types, period of incubation, their sequelæ and complications. The anatomical changes which occur are described, also the general pathology. The work closes with a chapter on diagnosis, prognosis, treatment, and prophylaxis.

Traumatic Injuries of the Brain and Its Membranes.—By CHARLES PHELPS, M. D., Surgeon to Bellevue and St. Vincent's Hospitals. Octavo, pp. xiv.—582. New York: D. Appleton & Co., 1897.

This book is a concise and systematic exposition of the injuries to which the brain is subject. It should prove interesting to every surgeon and practitioner. Not the least valuable part of the book is the record of three hundred cases verified by necropsy.

REMINISCENCES.

By EDWARD BORCK, A. M., M. D., Saint Louis, Mo.

Chapter V.—Continued.

A PRIVATE HOSPITAL.

By 1885 Dr. Newcomer had learned that to do justice to a patient upon whom a capital operation was to be performed required a place specially prepared for the purpose; the proper conveniences are not to be obtained at the most conveniently appointed residences. Dr. Newcomer, therefore, conceived and executed his idea of a private hospital, as at that time there was not a single hospital in the city to which physicians could send and treat their own patients; if patients were sent to the hospitals, they were appropriated by the consulting surgeon or physician. What is one to do in order to keep his own patients? The only independent way is for the doctor to treat them at his own home.

Dr. Newcomer mentioned his plan to some of his medical friends, who met it with opposition and did all in their power to discourage it. "It cannot well be done." "The profession would object." "In New Orleans Dr. Stone could do it, but to attempt such a thing in St. Louis—preposterous! You would get all the doctors down on you." By this I presume they meant the consultants to the hospitals controlled exclusively by themselves.

Notwithstanding this discouragement Dr. Newcomer established a small private hospital (the first in the city) for the accommodation of his own patients, with an operating room fitted up with all the modern conveniences of that time. His colleagues hoped that he would succeed, and he did. But it was all wrong; a reputable physician should not own a private hospital; he should not be independent, but rather the tool or slave, with a high-sounding title—"consulting M. D."—of some hospital at the mercy of lay directors.

Dr. Newcomer announced the opening of his establishment and its object in a circular mailed to the profession. Now the "kickers" made themselves known. To speak of one among the hundreds—this was a conscientious code man. He immediately mailed his circular to the president of the medical society, calling his attention to this violation of the code—"a private hospital! an advertisement!"—and requested that the offender's ears and nose be amputated and the hospital closed, for he and others strongly objected to it. The president, however, was a very prudent man; he said: "*Noli me tangere.*"

Dr. Newcomer erred still more. He gave private instructions in surgery to small classes of practitioners, and allowed them to operate on their own patients under his direction. This was only done in Berlin; it was not feasible in St. Louis. The doctors demanded that the college professors take the matter in hand; the latter were willing, but the code is silent upon this point. The kickers, in a legitimate way, advertised the hospital. All the kicking did no good; the private classes prospered—and many, in reviewing the past, will think of the benefit derived at Dr. Newcomer's private hospital.

To teach practically one requires clinical material, to obtain which Dr. Newcomer established a clinic for the surgical diseases of children; not a free clinic, nor one of those charitable "free-to-all" clinics, conducted at some hospitals and medical colleges, with fifteen or twenty-five cents to pay for medicine; such clinics are against the professional judgment of the doctors.

To please the profession Dr. Newcomer adopted a new plan—a *pay clinic*, for those worthy people who could not possibly pay a full fee, but who had too much pride and integrity to accept charity. On certain days and hours the patients were given careful attention and could pay what they chose, although no less than a dollar was accepted. This plan worked admirably. The clinic was extensively patronized and charitable work was bestowed in the right direction for all concerned; but as soon as this clinic became a success it was condemned. Who ever heard of a "pay clinic"? Such was the common remark. Many physicians, however, took advantage of the opportunity and brought their patients for consultation to Dr. Newcomer's clinics.

How fortunate the code says nothing about taking a fee of any kind; it only forbids "gratis" treatment, so Dr. Newcomer was safe, to the vexation of many of the medical society members.

In conclusion, the author will say he has a personal and intimate acquaintance with Dr. E. B. Newcomer, and has followed his movements during his career and thinks he has been successful, although some may not agree with him. Many of his precepts have been followed, even by some who first deprecated Dr. Newcomer's methods; for example, the private hospital, of which we now have several. Time demands progress and improvement in all undertakings.

Dr. Newcomer is getting advanced in years, but is still able to enjoy "kicking," and no doubt will agree with me.

History repeats itself. Dr. Old will kick Dr. Young; Dr. Young will kick Dr. Old; Dr. Anybody kicks at Dr. Somebody, who in turn kicks at Dr. Everybody; and so on. Take care of your office. *Amen.*

Lactophenin is Perfectly Safe.—In his exhaustive chapter on tuberculosis, in *Wilson's American Text-Book of Applied Therapeutics*, Prof. James T. Whittaker, of Cincinnati, compares the antipyretics at various stages of treatment, and always speaks most favorably of lactophenin. Thus, in mentioning methods for lowering the temperature (p. 376), he says that salol is safer than acetanilid, antipyrin or phenacetin; "but as it liberates carbolic acid in the intestine, it should not be given in any case of stasis of the kidney;" and then he adds: "Lactophenin in the same dosage (five to seven grains) is efficacious and free from danger." To quiet pain (p. 384), "sometimes due to a toxic neuralgia," salol is safer than either phenacetin or antipyrin; the latter, in large doses, depressing the heart, "while lactophenin is a perfectly safe drug in the same dose (five grains every two hours)." This view is in accord with the judgment of the many reporters, that lactophenin is the safest of all the newer antipyretics.

NEW SUBSCRIBERS.

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER is growing. It has been growing for a long time. It will not stop. It prints a list of genuine subscribers every month. It does not print the names of persons requesting sample copies. Our list of new subscribers varies from 60 to 150 each month. Our August list consisted of 124 names; in September we printed the names and addresses of 74 new subscribers. Below we give the names of those who have

SUBSCRIBED IN THE LAST THIRTY DAYS:

- | | |
|-------------------------------------|-------------------------------------|
| H. S. Johnson, Texarkana, Ark. | C. A. Ansley, Three Oaks, Mich. |
| P. H. Mayginnis, Independence, Kan. | J. F. Merritt, Kingston, Texas. |
| J. H. Graham, Prescott, Ontario. | W. D. Vedder, Mansfield, Pa. |
| A. L. Yocum, Chariton, Iowa. | J. S. Cantrell, Noble, Mo. |
| Charles E. Snell, Brooklyn, N. Y. | A. L. Troy, Columbus, Ohio. |
| Ernest F. Slater, Buffalo, N. Y. | Wm. Thomson, Philadelphia. |
| G. W. Burton, Mitchell, Ind. | H. B. Coy, Philadelphia. |
| O. J. Roskoten, Peoria, Ill. | J. H. Nixon, Springfield, Mo. |
| E. R. Morrison, Nashville, Tenn. | W. P. Patterson, Springfield, Mo. |
| F. T. Meriwether, Asheville, N. C. | A. H. Gifford, Springfield, Mo. |
| T. E. Converse, Louisville, Ky. | F. E. Ross, Springfield, Mo. |
| J. M. Genshaw, Louisville, Ky. | A. L. Campbell, Springfield, Mo. |
| Thos. Hunt Stuckey, Louisville, Ky. | E. C. Beck, St. Louis. |
| W. B. Gossett, Louisville, Ky. | H. C. Moore, Forest, Tex. |
| H. R. Gibson, Richmond, Ky. | J. C. Walker, Marion, Ill. |
| J. O. Robinson, Bridgeport, Ky. | R. D. Mason, Missouri Valley, Iowa. |
| W. H. Barrett, Shelbyville, Ky. | Charles Schaer, St. Louis. |
| Charles M. Phelps, New York. | W. J. Loler, St. Louis. |
| J. H. Rowsey, Upland, W. Va. | J. J. Chandler, Lutesville, Mo. |
| E. Franklin Smith, New York. | J. W. Armstrong, Centralia, Ill. |
| J. H. Driver, Farribaville, Ark. | F. D. Rice, Kansas City, Mo. |
| P. H. McGurty, Hume, Ill. | T. B. Richardson, Dudley, Texas. |
| J. H. Charters, Flint, Mich. | James F. Miller, Garbers, Tenn. |
| E. W. Murray, Chillicothe, Mo. | W. W. Ellis, Buckner, Mo. |
| W. W. Pugh, Steele's Store, Texas. | G. W. Cale, Pittsburgh, Kan. |
| E. R. Espil, Potterville, Mich. | G. C. Eggers, St. Louis. |
| | M. F. Engman, St. Louis. |

A STORY BY DR. LYDSTON.

We have secured a story of intense interest from Dr. G. Frank Lydston, of Chicago, the author of "Over the Hookah." It will soon appear in this JOURNAL.

HISTORICAL SKETCH.

THE SARACENIC SCHOOL OF MEDICINE.

By JAMES MOORES BALL, M. D., of St. Louis.

SIX hundred years had passed since the appearance of Christianity, when the banners of a new religion were raised in Asia, and the Sons of Islam came upon the stage of the world's history. The Arabs, secure in the recesses of their country, and undisturbed by the turmoil of the times, from the remotest periods had lead a nomadic, patriarchal life. The proximity of the Christian civilization of the Greeks, and the mystic learning of the Persians, made but little impress upon this people, who, inspired by the teaching of Mohammed, overstepped their geographical bounds and, sword in hand, prepared to fasten the claims of a new religion upon the nations of the Orient. They who previously had watched their herds in peace, or, at the worst, had witnessed minor feuds and quarrels between hostile clans and tribes, now felt called upon to perform mighty deeds of valor in response to the watch-word: "There is no God but Allah, and Mohammed is his prophet!" These words found a mighty sympathy with the sons of the desert, whose easily-excited passions readily conferred a fiery zeal upon a movement of poetical richness and grandeur. Thus harmonized, the Arabs followed the teachings of a new light, who to them was a messenger from heaven, sent to convey a new religion, which Mohammed, in an ecstasy of eastern fantasy, evolved from the monotheism of the Jews and other falsely-conceived elements of Christianity. It was by means of this bond that all peoples of the East were drawn into a phalanx destined soon to press upon Europe.

At no time in their national life were the Arabians properly a barbarous nation. From their earliest periods, history, fiction, and, especially, poetry had been cultivated by them. If luxuriance of scene, acuteness of wit, greatness of conception; if colossal visions, the work of fantasy, constitute the essence of poesy, then no land has had such an abundance of poets as Arabia. The national character itself, which fed the imagination at the expense of solid thought, is sufficient to account for this.

In systematic works upon the history of medicine, it is stated that the Arabic period commences with the destruction of the Alexandrian library, in the year 640, and extends to the close of the fourteenth century. At the commencement of this era, the empire of the West was no longer in existence. The finest provinces composing it had been overrun by barbarians from the forests of Germany. From the ruins several independent kingdoms had arisen, of which the most important were those of the Franks in Gaul, the Visigoths in Spain, and the Lombards in Italy. The empire of the East was suffering a slow decline. The Turks had begun to appear upon the banks of the Danube. Less than a century had passed since preaching of Mahomet, yet, in that comparatively short time, his

followers had subdued all Arabia, India, Syria and Egypt. This man, who was at once warrior, legislator and prophet, fired all true believers with a thirst for conquest and a zeal for proselytism.

Wherever the Arab carried the crescent and scimeter to victory, there he settled and made Christian and Judaic civilization contribute to the culture of his mind. As many provinces and kingdoms which previously had been under Greek and Roman domination now became subject to the Arabs, so the scepter of scientific and literary learning passed into their hands. Scarcely a century had passed since the death of Mahomet before this gifted people were engaged in the conquest of letters. If the burning of the Alexandrian library would appear as an offering to fanaticism, it must be remembered that the later Caliphs of the family of Abassid atoned for Omar's offense by the fostering care which they bestowed upon education. Their conquests completed, their violence spent, and their Caliphs securely enthroned, they busied themselves with the accumulation of manuscripts. In matters of religion more tolerant than the Christian princes of the time, the Arabs gladly gave a refuge to Nestorians, philosophers and heretics, and employed them to translate the medical and philosophical writings of the Greeks. At a time when the nations of western Europe had not escaped from the barbarism produced by the Teutonic invasions, the cities of Bagdad, Samarcand, Cairo, Granada and Cordova were centers of intellectual activity.

The rapid growth of the Moslem intellect was due to various causes. Sapores I., King of Persia, who married the daughter of the Roman emperor Aurelian, employed Greek physicians at his court, and thus the doctrines of Hippocrates and Galen were disseminated throughout Persia. Sapores founded a school of medicine at his new capital, Jondisabour, which attained great celebrity. It is probable that Rhazes, Haly-Abbas and Avicenna were there educated. The school of Jondisabour was founded in the latter part of the third century. For centuries prior to the rise of Mahometanism, the Israelites had supported colleges in Bagdad, in Sura, and elsewhere. By the repeal of an ancient law granting public compensation to the philosophical and grammatical teachers of Athens and other cities, Justinian in the fifth century had driven the learned men of Greece to the four winds. The Syrian followers of Christ assisted in the development of the Arabic mind. How rapidly the oriental Caliphs advanced in mental culture, appears from the fact that in the eighth century Ali Walid ordered Christian scholars thenceforth to publish no more books in Greek, but in the Arabic.¹

Many of their sovereigns distinguished themselves by their appreciation of the importance of learning. Al-Mansur founded in Bagdad a school of medicine, richly endowed with means for instruction; built hospitals for the sick, and laboratories for the preparation of chemicals. It was here that Geber, the patriarch of chemistry, labored to produce a universal remedy. Hippocrates and Galen were the text-books used in this school, which is said to have been attended annually by six thousand students. It was here that chemistry, as a science, originated. The library of Bagdad at one time contained one hundred thousand volumes. Four centuries after the time of Al-Mansur, the Caliph Mostanser adorned the same

¹ Fort: *History of Medical Economy in the Middle Ages*; New York, 1883.

city by a celebrated college, which bore his name. This institution had no equal in the Moslem world, either in the elegance of the building, the number of its students, or the munificence of its endowment. This ruler was the last of the Caliphs who shed a ray of departing glory on his race. To protect the health of his subjects, Abderahmān caused the city of Cordova to be supplied with pure water, obtained from the distant Sierras, and conducted down the mountain slopes through leaden pipe. Zoölogical and botanical gardens were established in the same city. Christians, on payment of tribute, were permitted to reside unharmed in Cordova, and worshiped in their own way. These persons, known as Mozarabes, acquired a fluent knowledge of the Arabic tongue. At an early period in the history of the Moslem power in Spain "many noble dames at the Omniade court in Cordova had signalized themselves by the polished elegance of Arabic rhythm, as well as in the more laborious task of scientific investigation. Secluded life was prescribed by a law as rigid to Moslem women as the cloister regulations of northern Europe; yet, in defiance of such isolation, Saracen females obtained the honors of public recognition as a merited distinction for their poesies and the brilliant beauty of their written prose."¹ Hakem founded the great school of Cordova, which was to the Occident what Bagdad was to the Orient. In the tenth and eleventh centuries its roster of students included names from Africa, Syria, Persia, from France, and the Roman provinces of western Europe. And thus it came to pass that, in the twelfth century, Spain could boast of more than two hundred and fifty Arabian authors and seventy public libraries, of which that at Cordova is said to have contained two hundred and fifty thousand volumes.

Haroun Al Raschid translated for the benefit of his subjects many of the most valuable Greek books, and is said never to have traveled without a retinue of one hundred learned men. The Caliph, however, who of all others extended the sphere of Arabic learning, was Almamoun, the founder of libraries and schools in Bassora, Damascus and Bochara. In the eleventh century, Gehwer, to protect his subjects from medical charlatans, organized a college of skilled surgeons before whom all practitioners of medicine must appear for examination.

Notwithstanding the influence of their rulers, the light of literature did not reach the inner life of the people. It served, at the most, only as an ornament to the splendid court of the Caliphs. The despotism of the Koran pressed heavily upon the mind and restricted the reason. If the teachings of a Greek or Latin book were contrary to the Koran, the former was destroyed. Religious prejudice hindered original investigation and scientific experimentation. Owing to peculiar notions as to the manner by which the soul leaves the body, dissection of the human frame was regarded as a crime worthy of the greatest punishment.

In gynæcology and obstetrics only limited advances were made, since it was contrary to the teachings of the Koran that females should be treated except by physicians of their own sex. Whenever he desired to examine the female genital organs, the physician must employ a *sage-femme*. Arabic knowledge of obstetrics was woefully deficient. Albucasis, one of their best authors, gravely relates a case in which a woman cast off seven-

¹ Fort.

teen embryos at a single *jausse couche*. Nevertheless, they were the first to employ the obstetrical forceps; and a passage in the writings of Avicenna proves that the instrument was used in the delivery of living children. Albucasis described and delineated numerous instruments to facilitate parturition, and among them he figures a short and a long forceps. These inventions were designed to supersede the ancient operation of craniotomy. Unfortunately the Arabian forceps was provided with teeth.

In chemistry and materia medica real advances were made. Traces of chemical operations can be found among the ancient Egyptians and Hindoos; yet the practice of chemistry, as a distinct art, originated among the Arabians, and by them was made tributary to medicine. To them we owe distillation and sublimation, the preparation of pills and tinctures, and the discovery of many chemical substances. The carbonates of soda and potash were confounded under the common name—alkali; and it was not until 1736 that they were distinguished by Duhamel. The Arabs made sulphur and lime, white and red precipitate, and knew of cinnabar and cobalt as pigments. Iron, copper, arsenic and silver preparations were used by them as remedies. Alcohol, aloes, camphor, cassia, musk, nux vomica, rhubarb and senna were added to the materia medica. The introduction of many of these drugs into practical medicine is due to the commercial relations of the Arabs with the people of India. They also had access to Hindoo and Persian writings.

The science of pharmacy originated with the Arabs. They deserve the credit of having set the first example of publishing pharmacopœias, or regular dispensaries, containing collections of authorized formulæ. To this day the names: alcohol, syrup, julep, naphtha, and many others, testify to an Arabic origin. The manufacture and sale of drugs seems to have been pursued under government inspection. In the ninth century a dispensary was started at Joudisabur.

To the Arabs we owe the introduction of cosmetics. The precepts laid down in the Koran, in relation to the care of the hair and beard, resulted in a multiplication of pomades, salves and washes. After luxurious customs had produced a withering of their fine physique and a loss of dusky beauty, they resorted to the balsams and aromatics of the Orient and invented cosmetics, hoping by this means to receive again the freshness and vigor of youth.

Nor were the Saracens ignorant of the occult sciences. Their lively and brilliant imaginations greatly favored the practice of alchemy and astrology, and many a man passed his life in barren reveries upon these subjects. These arts flourish most readily among a people in a state of imperfect civilization; for it is here that "the mind, impatient of the slow and cautious examination by which alone it can arrive at truth, launches at once into the regions of speculation and rashly attempts to lift the veil which is drawn around the mysteries of nature." The interpretation of dreams was a favorite subject with their medical authors; and one of them, Hassan Ben Hossain Al Khalal, wrote the biographies of seven thousand persons celebrated for their skill in this profession. A fantastic theory of the action of remedies was advanced by Alkhendi, who attempted to explain the activity of medicines by arithmetical rules, and believed that the correct geometrical admixture of drugs was of great importance in the

treatment of disease. Texts from the Alcoran, under the name of fetishes, were sold by Moorish priests, and were said to possess power to drive away evil spirits and prevent disease.

It is difficult to speak in measured terms of the influence which Arabic authors exerted upon the medical mind during the Dark Ages. Just as ancient Greek medical treatises had been translated into Arabic by the early followers of Mahomet; so, during mediæval times, just before the dawn of modern progress, Arabic writings on medicine and surgery were rendered into Latin. It is not too much to say that the entire medical practice of the Middle Ages was shaped by the Arabs. Even the works of Hippocrates and Galen were in Arabic. The youth of far-off Bavaria and Scandinavia flocked to the schools of Toledo, Seville and Salamanca. As early as the tenth century Christian princes gladly sent students to the Arabic colleges. In the twelfth century the Alcoran was translated into Latin. Arabic medical books were translated into the same language by Gerard of Cremona, and the commentaries of Averroes on Aristotle were made the subject of scholastic lectures in the University of Cambridge.

The Saracenic era forms the bond of union between ancient and modern times. The literature, arts and sciences of the Arabs, introduced into the countries they conquered, have in almost every instance outlived the rule of the conquerors themselves. "Widespread as was the empire of the Arab sword, it has been less extended and less durable than the empire of the Arab mind."

The celebrity of the Saracenic school of medicine is to be attributed, not to any original investigations in science, or to the existence of an independent literature, but rather to the ignorance and superstition of the European mind at this period. In no age were the immoralities of the clergy greater than from the seventh to the thirteenth century. At no time was the understanding so clouded, the intellect so debased. It was thought impossible to improve upon the literary and scientific productions of the Greeks, and Aristotle was supposed to have reached the limit of human learning. Few of the people could read and write, and many contemporary monarchs were equally uneducated. The only schools were the monasteries, and the only teachers the debased ecclesiastics. It is not to be wondered that so little progress was made; but, on the contrary, it is surprising that ancient Greek learning was not entirely lost. The Saracens, once their desire for conquest was appeased, dug up the manuscripts which long had been hidden in the depths of libraries, translated them, appropriated the doctrines therein contained, impoverished them with additions, and transmitted to posterity only enormous compilations. Such, in a word, are the works of Rhazes, Hali-Abbas, Avicenna, Averroes, and Albucasis, the most celebrated of their medical authors. With the decline of their political power, the intellectual kingdom of the Arabs came to an end. In 1236, Ferdinand the Holy, of Castile, overthrew Cordova, and Granada remained the only stronghold of the Moslem power on the continent. After the capture of Bagdad in 1258, Arabic learning declined in the East. Step by step the Saracens were driven from France and Spain. When, in the year 1491, Ferdinand the Catholic, after a siege lasting a twelvemonth, succeeded in planting the standard of the cross upon the

towers of the Alhambra, the Saracenic school of medicine ceased to exist; but not so its influence, as we have abundant evidence to show.

Even if the art of healing among the Arabs had been only a continuation of that of Greece, it would never have possessed the pure, active and natural tendencies of Hellenic culture, for which the Orient is no suitable home. Although the everlasting lamp of human learning was never extinguished among the Arabs, yet it was obscured by the mists of superstition, of fanaticism, and a boundless ecstatic fancy for magic and the black arts. Thus were concealed the bequests of antiquity, which, increased but little and defaced by many additions, continued to govern the entire medical faculty of the Middle Ages. When, however, by moderns it is stated that the entire mass of Arabic medical lore consists in chaff (and the barbarous Latin, into which their works were translated, does not present an inviting field for study), it must still be borne in mind that many golden kernels could, doubtless, be found in the refuse, if a person familiar with the Arabic language had the time and inclination to delve among the original works, many of which, still untranslated, lie mouldering in ancient libraries, awaiting their deliverance.

“With the majority of people one of the signs that the grand climacteric has been reached and passed, or at least is very close at hand, is the presence of vague, rheumatic pains of a transitory character, but present somewhere almost continually. Sometimes (we might say in the majority of cases) the sensation is scarcely severe enough to be called a pain, but rather a soreness of the muscles, which is intensified on the approach of cold weather or preceding a change of weather, and especially before long wet spells.

“In the morning on awakening the patient will feel sore all over, or possibly some joint will be affected, usually one which in years gone by has been the seat of some injury, such as a fracture, a sprain, or a severe wrench.

“Medical authors have not considered this form of rheumatism of sufficient importance to give it a name, and most of those so affected accept it as one of the penalties of advancing years, or as something for which medication is useless.

“Tongaline liquid, teaspoonful doses in a wineglassful of hot water, or tongaline and lithia tablets, two at night upon retiring and two on arising, washed down with copious draughts of hot water, will in the course of a short time remove the cause and subdue the trouble.”

The American Academy of Railway Surgeons.—The following are the new officers: President, Dr. R. Harvey Reed, Columbus, Ohio, First Vice-President, Dr. W. J. Mayo, Rochester, Minn.; Second Vice-President, Dr. Arthur D. Bevan, Chicago; Secretary, Dr. C. D. Bryant, Omaha. Place of meeting, Chicago, 1898.



Located.—Dr. W. T. Royce, recently of Galesburg, has located in Yates City, Ill.

New Officers.—The LaSalle County (Ill.) Medical Society has elected the following officers: President, T. W. Burrows, of Ottawa; Vice-President, G. A. Diens, Streator; Secretary and Treasurer, Edward W. Weis, Ottawa.

Located in Illinois.—Dr. Charles D. Thomas has located in Peoria; Dr. Gilbert Fitzpatrick, in Savanna; Dr. Theo. Schweer, in Beardstown; Dr. A. B. Montgomery, in Reynolds; and Dr. W. P. Sherman, in Aurora.

Located in Iowa.—Dr. H. C. Stream has located in Tingley; Dr. E. E. Sowles, in Goodell; Dr. O. W. Phelps, in Britt; Dr. Beatty, in West Branch; Dr. Laura Armstrong, in Ft. Dodge; Dr. Frank Aldrich, in Lenox; Dr. Kenney, in Bridgewater; Dr. W. J. Baur, in Independence; Dr. T. H. Marsden, in Rock Rapids; Dr. Frank M. Fuller, in Keokuk.

Died.—Dr. Hatch, of Carthage, Ill., died recently at the age of sixty.

Poor Kansas City!—Another medical college has been born in Kansas City, Mo. Every doctor in that village will be a “fessor”.

Growing.—The Saint Louis Academy of Medical and Surgical Sciences is growing satisfactorily. One of the recent additions is Dr. M. F. Engman, whose article is to be found in this issue.

Address on Medical Education.—R. H. Jesse, LL. D., President of the Missouri State University, will deliver an address on medical education before the Southeast Missouri Medical Association, at Malden, November 2d. No doubt he will handle the subject in a satisfactory manner.

The Oldest Doctor.—The oldest physician in the United States is Dr. Stephen Adams, aged ninety-four, who lives in West Newfield, Mass. He was graduated in 1828. Who can show a better record?

Lecturing Again.—Dr. Wm. Porter, one of the best-known laryngologists in this country, is again lecturing in the St. Louis College of Physicians and Surgeons.

Death of Dr. Mullen.—In the death of Dr. Alexander J. Mullen, St. Louis loses an extraordinary old citizen. He lived eighty-four years, and in that time ran away from home as a boy, shipped as stowaway, became a sailor, had countless maritime adventures in all parts of the globe, almost perished from shipwreck in the West Indies, studied medicine in Louisville, practiced throughout Indiana, served in the late war on the

staff of Gen. Rosecranz, who was his bosom friend, settled in St. Louis, traveled over Europe, gaining fame and friends by his keen surgical knowledge, returned to St. Louis and acted as a member of the board of health. Few men could endure all these toils and vicissitudes and hope to reach the serene old age of eighty-four. Perhaps the reason of his survival could be found in his iron Irish constitution. He leaves three children.

Southeast Missouri Medical Association.—This Society will hold its twenty-first semi-annual meeting in Malden, Mo., November 2, 3 and 4, 1897. The following program will be rendered: Tuesday evening, November 2d, the Society will listen to an address of welcome and response, after which R. H. Jesse, LL. D., President of the Missouri State University, will give an address on "Medical Education." The following papers are on the list: "Rural Surgery," A. D. Blomeyer, M. D., Cape Girardeau; "Report of a Surgical Case," A. E. Simpson, M. D., Charleston; A Paper, F. Kinsolving, M. D., Hornersville; "Pneumonia," I. W. Powell, M. D., Holcomb; "Endometritis," J. M. Rowe, M. D., Charleston; "Report of Meeting of Mississippi Valley Medical Association," H. L. Reid, M. D., Charleston; "The Medical Colleges of Missouri," W. R. Goodykoontz, M. D., Caledonia; A Paper, W. P. Howle, M. D., Oran; "Report of Interesting Cases," Van H. Bond, M. D., Cotton Plant; "Mental Suggestions as a Means of Therapy," C. W. Brown, M. D., Campbell; "Synopsis of and Salient Points Gathered at Jubilee Meeting of American Medical Association," M. Rosenthal, M. D., Kennett; "Report of Progress in Obstetrics" (by appointment), A. W. Chapman, M. D., Charleston; discussion to be opened by T. W. Cotton, M. D., VanBuren; "Report of Progress in Surgery" (by appointment), A. A. Bondurant, Cairo, Ill.; discussion opened by J. J. Norwine, M. D., Bismarck; "Report of Progress in Medicine" (by appointment), G. T. VanCleve, M. D., Malden; discussion opened by J. D. Porterfield, M. D., Cape Girardeau; "Report on New Remedies, with Special Reference to Serum Therapy and Use of Antitoxin in Diphtheria" (by appointment), F. L. Keith, M. D., Farmington; discussion opened by C. F. Green, M. D., Poplar Bluff; "Report of Progress, Diseases of Children" (by appointment), C. A. Anthony, M. D., Fredericktown; discussion opened by G. W. Vinyard, M. D., Jackson. The officers for 1897-98 are: J. P. Sebastian, M. D., President, Patterson; I. W. Powell, M. D., Vice-President, Holcomb; M. Rosenthal, M. D., Corresponding Secretary, Kennett; G. S. Cannon, M. D., Recording Secretary, Jackson; R. T. Henderson, M. D., Treasurer, Jackson.

Appointed.—Dr. E. H. Gregory, son of Dr. E. H. Gregory, of St. Louis, has been appointed Instructor in Embryology and Histology at the Harvard Medical School.

Tri-State Medical Association of Mississippi, Arkansas and Tennessee.—The Tri-State Medical Association of Mississippi, Arkansas and Tennessee, will meet in Memphis Wednesday and Thursday, November 17 and 18, 1897. The rapid growth of this Association has not been equaled by any other district medical society in the South, over two hundred physicians being present at the meeting last November.

No pleasanter place to visit can be found than the Queen City of the Mississippi Valley at this season of the year, when all her business interests and amusements are in full blast. All physicians residing in the three States from which this Association draws its membership are urged to attend the meeting this fall and to connect themselves with such an aggressive medical organization.

Physicians desiring to contribute papers will please send titles to the Secretary, Dr. Richmond McKinney, Continental Building, Memphis, Tennessee, who will also be glad to furnish any information concerning the approaching meeting of the Association that may be desired.

Treatise on Guaiquin.—Messrs. McKesson & Robbins, of 91 Fulton street, N. Y., have just issued a neat brochure on Guaiquin, a new quinine for the treatment of anæmia, malaria and diseases characterized by septic infection or bacterial fermentative disturbances of the gastro-intestinal tract. The book can be obtained free by addressing the publishers and mentioning this JOURNAL.

Large Classes.—Most of the medical colleges in this city have opened with large classes in attendance. The Barnes leads with over five hundred; the P. and S. and Marion-Sims have three hundred each; the St. Louis Medical College has about eighty students, and the Beaumont Hospital Medical College is credited with about eighty; the Missouri Medical College claims about one hundred and sixty; the Homœopathic Medical College and the American (Eclectic) have good classes. There are nearly eighteen hundred medical students in St. Louis this winter.

"The Alkaloidal Clinic."—We are glad to see the great improvement in this excellent Chicago journal. Waugh and Abbott are progressive editors.

Mississippi Valley Medical Association.—The officers elected for the ensuing year were: John Young Brown, M. D., St. Louis, President; A. P. Buchman, M. D., Fort Wayne, Ind., First Vice-President; A. J. Ochsner, M. D., Chicago, Second Vice-President; Henry E. Tuley, M. D., Louisville, Secretary. The next meeting of the Association will be held on the second Tuesday in November, 1898, at Nashville.

Medical Schools Must Teach in English.—The Illinois State Board of Health has passed a resolution that after May, 1901, no school of medicine or midwifery will be recognized unless its instruction is given in the English language. A number of schools of midwifery in Chicago will be affected. After May 1, 1898, no candidate for license to practice medicine in the State will be examined unless he gives documentary evidence of a preliminary or basis education equivalent to that of a high school course.

Preliminary Programme of the Southern Illinois Medical Association.—The following papers are announced for the twenty-third semi-annual meeting of the Southern Illinois Medical Association, to be held at Fairfield, Illinois, Thursday and Friday, November 18 and 19, 1897:

"Recent Work in Cancer," by Dr. G. Wiley Broome, of St. Louis. Discussion opened by H. L. Galt, of Sparta, Illinois, and C. H. Starkel, of Belleville, Illinois.

"Some Differential Diagnostic Points in Appendicitis, and Its Operative Indications," by Dr. L. T. Riesmeyer, of St. Louis. Discussion

opened by H. C. Fairbrother, of East St. Louis, and Walter Watson, of Mt. Vernon, Illinois.

Paper by C. W. Hall, of Kewanee, Illinois. Subject unannounced.

Paper by Jas. B. Herrick, of Chicago, Illinois. Subject unannounced.

Paper by Wm. C. Sibley, of Fairfield, Illinois. Subject unannounced.

Paper by A. Wetmore, of Waterloo, Illinois. Subject unannounced.

"Maternal Impressions," by L. H. Corr, of Carlinville, Illinois.

Discussion opened by C. G. Reagan, of Du Quoin, Illinois.

"Yellow Fever—Clinical Aspect and Treatment," by J. C. Sullivan, of Cairo, Illinois. Discussion opened by Wm. R. McKenzie, of Chester, Illinois.

"Choroiditis in Children," by Dudley S. Reynolds, of Louisville.

Discussion opened by A. C. Corr, of Carlinville, and James Moores Ball, of St. Louis.

"Quinine Amaurosis," by James Moores Ball, of St. Louis. Discussion opened by E. A. Davis, of Murphysboro, Illinois, and Dudley S. Reynolds, of Louisville.

"Medical Scepticism," by O. B. Ormsby, of Murphysboro, Illinois.

Discussion opened by J. T. McAnally, of Carbondale, Illinois.

"The Relation of Catarrhal Conditions of the Nose and Lachrymal Ducts to Corneal and Conjunctival Disorders," by A. C. Corr, of Carlinville, Illinois. Discussion opened by Dr. H. W. Loeb, of St. Louis.

"Antiseptic Midwifery," by J. W. Armstrong, of Centralia, Illinois.

"Vaginal Atresia—Surgical Treatment," by O. T. Moore, of St. Louis. Discussion opened by J. I. Hale, of Anna, Illinois, and Geo. F. Hulbert, of St. Louis.

"Some Remarks Concerning the Pathology and Treatment of the Genital Tract of Parturient and Puerperal Women," by C. H. Bacon, of Chicago, Illinois. Discussion opened by J. L. Wiggins, of East St. Louis, Illinois, and Earl Green, of Mt. Vernon, Illinois.

"Endometritis," by E. C. Dudley, of Chicago, Illinois. Discussion opened by T. S. Dodds, and R. E. Farris, of Anna.

"Puerperal Eclampsia," by F. M. Agnew, of Makanda, Illinois. Discussion opened by H. V. Ferrill, of Carterville, Illinois, and J. J. Gordon, of Cairo, Illinois.

"The Relationship Between Syphilis and Cancer," by Geo. N. Kreider, of Springfield, Illinois. Discussion opened by Emory Lanphear and A. H. Ohmann-Dumesnil, of St. Louis.

"The Ideal Operation for Hemorrhoids," by J. F. Percy, of Galesburg, Illinois. Discussion opened by W. F. Grinstead, of Cairo, Illinois, and L. T. Riesmeyer, of St. Louis.

"Medical and Surgical Treatment of Appendicitis," by C. W. Sibley, of Fairfield, Illinois. Discussion opened by J. H. Mitchell, of Mt. Vernon, Illinois, and E. E. Fike, of Centralia, Illinois.

The following are the officers of the Association: President, H. C. Mitchell, of Carbondale; First Vice-President, C. F. Wilhelmj, of East St. Louis; Second Vice-President, W. F. Grinstead, of Cairo; Secretary, J. O. DeCourcy, of St. Libory; Corresponding Secretary, J. I. Hale, of Alto Pass; Treasurer, H. L. Gault, of Sparta.

PUBLISHER'S DESK.

THERAPEUTIC PROGRESS.

By GEO. H. THOMPSON, A. M., M. D.,

Professor of Materia Medica, Therapeutics and Emergency Practice, St. Louis College of Physicians and Surgeons.

We all have a more or less routine treatment for the various inflammatory affections of the skin that we are called upon to treat. Even the most obstinate forms of chronic eczema of the leg, whether caused by varicose ulcerations or not, can be cured in time under the ordinary routine methods if we can secure for the affected part absolute rest. In fact, rest is the one consideration which heretofore has been the *sine qua non* in such conditions. It is the easiest to prescribe and the hardest prescription to have filled. Outside of the hospital, except in the most serious conditions affecting the life of the patient, it is practically impossible to exact. This being the case, we must do the best we can. It will not do to tell the patient that unless he stops earning his living we will throw up the case, that we can not risk our reputations in attempting the impossible. The patient has a right to the best he can get *under the circumstances*; and we are here to do what we can for him, in spite of all drawbacks.

In such cases the most active healing agent obtainable should be resorted to; and, in the light of the prodigious strides made by science in the last few years, this may be difficult to choose. Antibrule has given the utmost satisfaction wherever I have had occasion to employ it. It is antiseptic in a high degree, non-irritating and analgesic. As an agent hastening granulation it is probably without a peer. To illustrate its effects I will briefly describe a few cases where it has been successfully used:

August 15th, Miss J. called to be treated for an ulcer on the back of her left foot. It was very painful and had developed during the previous six weeks, and at this time was of the area of a ten-cent piece. It was first thoroughly cleaned, then a dressing of antibrule with gauze applied directly to the ulcer, which dressing was repeated daily. The first application relieved the pain at once, patient continued at her work, and was so far well on the tenth day that it was deemed unnecessary further to treat the sore other than to enjoin absolute relief from pressure at the tender spot.

August 16th, Mrs. S., aged 46, mother of six children, came to see me about her leg, which was affected with a chronic ulcer. Inspection showed it to be the size of a quarter, surrounded by an extensive area of inflammation of the weeping eczematous variety. She had used a number of salves and various applications, but they were but temporarily beneficial, if at all, and never healed the ulcer. She was obliged to be on her feet most of the time, so that the injunction of rest was of no avail. I instructed her how to clean the ulcer, and directed her to apply a rubber bandage during the day, and at night carefully cleanse the ulcer, apply antibrule upon and

around it, bandaging it with a simple gauze. Improvement was immediate—relief from the painful itching and burning was at once experienced. The granulations took on a healthy character and the eczema subsided. At the present date, October 1st, she is practically cured and requires only care to continue well.

Miss C. came into the office a few weeks ago with her hand and wrist burned on the back. It was very painful and she wanted immediate relief. An application of antibrule afforded the relief sought, and applications at home twice a day cured her in less than a week.

A month ago Mr. T., a bar-keeper, came to be treated for erysipelas of the hand. Dressings of antibrule daily applied arrested the spread in twenty-four hours and cured in six days.

This new candidate for professional favor is of a beautiful lemon yellow color. It is recommended as a dressing in all forms of inflammatory and irritative skin diseases, or for the treatment of wounds, abrasions or anything requiring a local antiseptic cicatrizant. That these claims are borne out by experience explains why antibrule has taken the profession by storm.

"Grip."—C. A. Bryce, A. M., M. D., Richmond, Va., editor of *The Southern Clinic*, in writing upon the above subject, during an epidemic of la grippe, said:

"For the past four weeks or more we have met with five times as much grip as anything else, and the number of cases in which the pulmonary and bronchial organs have been very slightly or not at all involved have been greater than we have noted in former invasions. On the contrary, grippal neuralgia, rheumatism, hepatitis and gastric congestions have been of far greater frequency, while in all the nervous system has been seriously depressed.

"The fatalities from pneumonia, meningitis, and other complications have been fewer, showing plainly that we are gradually gaining an immunity from this zymotic invader. With each succeeding visitation of this trouble we have found it more and more necessary to watch out for the disease in disguise, and to treat these abnormal manifestations; consequently, we have relied upon mild nervous sedatives, anodynes and heart-sustainers, rather than upon any specific line of treatment. Most cases will improve by being made to rest in bed and encourage action of skin and kidneys, with possibly minute doses of blue-pill and quinine, or calomel and salol. We have found much benefit from the use of antikamnia and salol in the stage of pyrexia and muscular painfulness; and later on, when there was fever and bronchial cough and expectoration, from antikamnia and codeine. Throughout the attack and after its intensity is over the patient will require nerve and vascular tonics and reconstructives for some time."

Resinol in Parasitic Sycosis.—Ring-worm of the bearded portion of the face, or "barber's itch," as it is commonly called by the laity, is always a stubborn affection, especially in its later stages. This is due to the fact that the ring-worm fungus rapidly extends from the surface to the hair-follicles, as is evidenced by the breaking off and falling out of the hair.

In consequence of the irritation produced by the growth of the fungus in the follicles inflammation results, and there is a formation of nodules on the surface of the skin. This is reddened and glossy, and more or less covered with pustules, and the nodules in the course of time are apt to break down and discharge a glutinous material which dries into crusts.

In the treatment of parasitic sycosis, cleanliness is the first requisite. The parts should be washed with soap and hot water, and the hair in the affected region thoroughly epilated. After this has been done, unguentum resinol should be applied. Experiments have shown that it rapidly destroys the parasite, without producing irritation.—*American Journal of Dermatology and Genito-Urinary Diseases.*

Obesity and Allied Complaints.—The bottle of phytoline ordered of you some time ago, for a case of obesity, acted like a charm; patient lost forty pounds while taking three-fourths of the bottle, with no disturbance of the general health whatever. Phytoline is the most efficient, powerful and reliable anti-fat now before the profession, and I can heartily recommend it in all cases of obesity and allied complaints.

Gray, Texas.

A. C. POE, M. D.

Sanmetto in Cystitis and Prostatic Troubles.—Sanmetto yields uniformly good results at my hands. I have prescribed it in chronic cystitis of long standing, where the standard remedies failed, and effected a permanent cure. It is certainly ahead of anything I have ever used for enlarged prostate, and in fact for all prostatic troubles.

Farley, Iowa.

J. F. LAMBERT, M. D.

Sanmetto in Enuresis Nocturna.—Mrs. H. M. Robertson, M. D., of Middleport, N. Y., writing, says. "I have just received a letter from the mother of the girl to whom I gave the sanmetto for nocturnal enuresis, and she assures me that her little girl has no more trouble of that kind, nor has had for some time; so thinks she is cured. I feel sure this case has been cured by sanmetto, for it was an obstinate case, and did not seem to yield to anything before I gave her the second bottle of sanmetto, although I had tried all the usual remedies. I believe in giving credit where it is due."

Southern California.—We desire to call the attention of physicians to the resumption of through winter service to California by the Wabash Railroad. We offer many attractions to those who are feeble or in ill health, namely: luxurious through sleepers from St. Louis to Los Angeles, also a library car (provided with easy chairs and current standard literature) for day use, and a nicely-appointed dining car. The fast time of last season has been slightly accelerated and the trip from St. Louis to Los Angeles can now be made in about two and three-fourth days. Our through service is operated twice a week, leaving St. Louis Wednesday and Saturday nights.

C. S. CRANE,

General Passenger and Ticket Agent, St. Louis, Mo.

Mason's Antiseptic.—While down in Arkansas a few days since, I was called to see a case that the hand had been amputated a few days before, and the doctor that had been attending had used peroxide of hydrogen on it for antiseptic purposes, which had caused extensive sloughing.

I used the small sample of your Mason's antiseptic that you gave me on the trip, and it stopped the sloughing at once. I left it and he was using it as a dressing, and wants you to send him a seventy-five cents bottle and gave me the money for you.

Send it at once by express to Knobel, Arkansas (Post-Office, Stone-wall, Arkansas); name, Mr. W. H. Purdue, and call at my office for the money. Don't delay this, for I think that under the other treatment he would have lost his arm, or perhaps his life; and I further think that this will save him. Yours truly,
J. E. CHAMBERS, M. D.

A Reliable Food.—I have received the "Nursing World Clinical Records" and samples of your Imperial Granum, although it was unnecessary to send the latter to acquaint me with its value, as we have a living example in our only son of the worth of Imperial Granum, and I have prescribed it constantly for eleven years, and always with the very best results. Yours very truly,
— — —, M. D.

September 2, 1897.

Clinical Records and samples of this celebrated food free, charges prepaid, on application to John Carle & Sons, 153 Water street, New York city.

An Antidote to the Two Great Symptoms.—The value of antikamnia consists in its rapid effect in alleviating the suffering of the patient while more radical treatment is working a cure. While endeavoring to rid our patient of his neuralgia, rheumatism, typhoid, intermittent or malarial fever, we secure him relief from pain and intermission of fever. We have, in short, in this drug, not a remedy for any disease, but a most useful antidote to the two great symptoms—pain and pyrexia.—*Medical Reprints*, London, Eng.

The Superiority of Sugar-Coated Pills—"Warner"—is demonstrated by a wealth of evidence. There is accumulated evidence of perfect results obtained by the medical profession which has used them for over forty years. There is evidence in the award granted by the Columbian Exposition, 1893, upon the following grounds: "The pills are of uniform size, the coating is perfect and protects the pills indefinitely, samples 27 years old being shown readily soluble in hot or cold water." A soft pill mass protected indefinitely from atmospheric conditions is certainly the perfection of pill making. There is evidence to be found every day by suspending a Warner pill on a mosquito netting in water from 98° to 100° and watching it dissolve. This test is conclusive, as the conditions most nearly approach the natural conditions present in pill medication. It will show the superior solubility of the Warner product over pills made by any other process. It will guide the pharmacist in his specifications.—*Monthly Retrospect of Medicine*.

THE TRI-STATE MEDICAL JOURNAL ^{AND} PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., NOVEMBER, 1897.

No. 11.

CLINICAL LECTURE.

CLINIC ON DISEASES OF CHILDREN.*

By PROF. A. CAILLÉ,

Visiting Physician German Hospital; Attending Physician Post-Graduate Hospital;
Consulting Physician Isabella Home and Hospital, etc., etc.

GENTLEMEN:—I wish to draw your attention to this apparatus for securing a child who is a sufferer from Pott's disease. This patient has Pott's disease in the lower region of the spine; abscess has formed and is now discharging through the intestine. By means of this apparatus the child can be readily handled.

(The device consisted of an iron frame which encircled the child. Stretched across it and fastened to the inside of the frame was an oblong piece of canvas, upon which the child was laid. The child was fastened in by means of broad bandages.)

Here no pressure can be felt, the child can be moved about, and the patient is very comfortable. This is a device which you should all remember. In this case an attempt was made to place on a plaster of Paris jacket, but it failed in securing comfort. In all cases which will not do well in jacket, this device is good.

* Held at the New York Post-Graduate Medical School and Hospital, on November 9, 1897, and reported expressly for the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

CASE II.—This is an idiot. She is fourteen years old and was quite well up to the age of two years, when she had an attack of cerebro-spinal meningitis. The result of this illness I here show you. She is, of course, a great burden to her parents, who insist that something shall be done for her. Craniectomy has been advised. This is done with the idea of making room for the brain to grow. In this case the brain was perfectly well developed up to the age of two years, when an inflammatory process set in and formed massive adhesions in the brain substance. In this case craniectomy would be of no value. There are a number of institutions for such children who are in this deplorable condition and where she should go. The parents would rather have an operation done which would cure or kill. I can advise no operative interference, because the meninges are bound down and the adhesions are so dense that it would not allow the brain to fulfill its function. These cases, gentlemen, are often seen in museums; they shave off the hair and represent them as "Wild Men of Borneo." These cases do not do well after operative interference. The operation would not kill her, neither would it cure her; and it is not right to submit the child to an operation when no good can come from it.

CASE III.—This little one you have twice seen before, but new features have developed which I wish to call your attention to. She is a girl of twelve years of age, whose case was diagnosticated by us as one of hepatitis due to malaria, and the plasmodium was found in the blood. During the last two weeks marked ascites has developed. The fluid has pushed the liver upwards; the diaphragm and upper liver dullness is one inch higher than it should be. Respiration is very rapid. The child has had anti-malarial treatment—quinia, Warburg's, etc., but methylene blue has not yet been tried. This child should be left with us in the hospital, as water may have to be taken out. In cases of this kind, where the liquid interferes with respiration, tapping should be done. If it reaccumulates, make drainage. I usually do this with a flexible tube introduced through a trocar allowing the end of the tube to remain in the abdominal cavity. The end of the tube should be closed with clamps or cotton. It can be left in a number of weeks and the liquid let out several times a day if need be. A number of cures have been reported. We do not often see these cases in children; whereas adults over forty often have hepatitis with ascites. The interesting feature of this case is that the plasmodium is at the bottom of the trouble.

CASE IV.—Many of my colleagues are not familiar with apex pneumonia. Children are frequently taken sick with slight cough, little temperature and may be convulsions. If we examine the lungs we find no evidence of pneumonic inflammation. They fail to examine the apex. This is a case of left apex pneumonia. This is often treated as malarial fever, etc., and the apex is entirely overlooked. On percussion there is a slight dullness, and as you percuss you often find a sense of resistance under your finger. If you percuss without great force you will get resistance over the dull portion of the lung. This should be understood by every practitioner, as weeks of useless treatment may often be thus avoided.

There is no specific for pneumonia with high temperature. It is highly important that large quantities of water be given in such cases. After consolidation has taken place, iodide of potassium is, perhaps, the

best drug that you can give for resolution. I give iodide of potassium, grs. 10, t. i. d., per rectum; I give it in this way to avoid gastric disturbance.

CASE V.—This is a case of catarrhal pneumonia. I will give only the practical points of treatment. The question of high temperature always comes up in pneumonia; 106 degrees is not unusual. Convulsions are not unusual in apex pneumonia. If the temperature is very high, give anti-pyretics, but do not let this become a habit. In this case note that the respiration is very labored. According to the chart the temperature was 101° this morning, and not so high as the other baby with apex pneumonia. We have here a different condition of things entirely. Breathing is labored and rapid, temperature not typical, cough is loose and very much like that of whooping-cough, and the heart's action is very rapid. Here the child is in a dangerous condition, because both lungs are filled with viscid or muco-pus. We should endeavor to stimulate the child in order that this secretion will get into the circulation as soon as possible. The child is always in danger, because this is like a septic process; toxins are absorbed, get into the circulation, and so your treatment must be active in such cases. The best stimulant that I know of is camphor, as given in the following prescription:

℞ Camphor..... gr. jss to iij
 Acid benzoic gr. iij
 Chocolate gr. vi
 M. S.—Three or four times a day.

This increases the heart's action and expectoration; if the heart's action is very rapid you may add some digitalis. Continue the treatment for three days. If camphor is irritating to the stomach, give other drugs, such as strychnine.

CASE VI.—This little fellow is brought to us from the babies' ward. A diagnosis of axillary abscess was made, for which an operation had been performed.

Now, it is not an axillary abscess that I wish to demonstrate to you to-day, but some lesion in the thorax. Percussion shows consolidation, for here is absolute dullness. Placing your finger-tips on one side you will note good fremitus; on the other side, when the child cries, fremitus is almost entirely absent. According to your text-books, these signs should show an effusion here or the remnants of an old pleural pneumonia. The only way to decide this question is by the introduction of a needle. By listening here you get very distinct bronchial breathing; now, bronchial breathing, dullness and vocal fremitus mean consolidation of lung. Any doubt that may exist can only be cleared up by the needle. So we shall puncture and see what we can find. In operating it is better to have some one hold the child in the lap. In order to increase the intercostal spaces, you raise the arm; then, by pressing the fingers deeply into the space, you assist in keeping the ribs apart. Here, now, I show you the fluid which I have removed. It is serous but almost purulent in character. The dullness at the apex was due to pressure of the lung, which had been pressed upwards by the fluid. In a case of this kind do not wait too long before taking out the fluid. The temperatures, which range from 100° to 103°, and which keep up for weeks with no other evident reason for their existence, show that the fluid is doing damage and must be removed. These

cases should be managed the same as an empyema—by placing in a drainage tube, etc. This child is about ready for operative interference. There is no good reason for waiting, as the child will become reduced and the chances of recovery are not so good. In empyemas I always resect, because it is not difficult to do this and is absolutely the best way of procuring drainage. One should remember that the ribs cover one another, like shingles, and, hence, it is best to resect. Our best surgeons recommend resection. Wherever pus exists it should be removed, is a good surgical truism.

CASE VII.—Please observe how this child holds its hands and hear how pitifully it cries. The joints of the wrist are swollen and painful. This boy, four and one-half years of age, had measles six weeks ago and developed nephritis. The swellings at the wrist were first observed in the babies' ward. The elbows seem to be somewhat swollen, too. We find these rheumatic swellings at the wrist not unusual, and you will often find it following any infectious disease—measles, diphtheria, etc. Now, what is the causative factor? Is it a microbe? I cannot say. The practical question that arises is: How can we overcome the swelling which is so painful? Salicylic acid is probably the best drug at this time for rheumatic affections, and it is proper to give several large doses. Salicylate of sodium is excellent. Personally, I like iodide of potassium, and I frequently add this to the salicylate of sodium mixture. Both these drugs are soluble in water and can be given by the rectum; do not give them by way of the mouth unless the tongue is clean. Some physicians like to give veratrum viride in combination with the salicylate of sodium, and this is a good plan if the heart acts well. What I like is the following:

℞ Sodii salicylat.....	5 jss
Potas. iodidi.....	5 ss
Tr. aconiti.....	gtt. x to xv
Aquæ destill.....	ʒ ij

M. S. One teaspoonful at a dose.

This seems to act specifically through the blood, reduces the heart's action, and always has done well in my hands.

For the local application, the best is cold compresses. Place the child's joint on a splint, in such a position that the muscles will not make strain upon the joint.

CASE VIII.—The next case that I present to you is an ordinary case of chicken-pox. I wish to direct your attention to one point in particular. According to your text-books, the vesicles or pustules are umbilicated in small-pox; but in chicken-pox this is said not to be so. It is so stated. This is absolutely untrue, as you will see in this child, who will be passed around for your inspection, upon whose skin I have marked the parts I wish your attention called to. The truth is that you do have umbilication in chicken-pox. But please note that in small-pox you have a red area around the eruption which will serve to distinguish it. In local epidemics here there is a fight over nearly every case of suspected small-pox. The point shown is well taken and is worthy of your attention.

CASE IX.—This, gentlemen, is a case of vulvo-vaginitis. You see here the purulent discharge of about two weeks' duration. The physician

who sent the case in to us found the gonococcus in the pus, and so it is proven to be of gonorrhœal origin. One point that I wish to raise is that the majority of cases of vulvo-vaginitis in children are of gonorrhœal origin, and fourteen cases out of twenty-one examined showed the presence of the gonococcus.

If in the treatment of this condition you apply some antiseptic lotions, cod-liver oil, iron, etc., as recommended in the books, the case will probably be drawn out for months. Destroy the gonococcus with nitrate of silver or some good caustic and apply it with cotton. In this case I will now swab out the vagina with a solution of nitrate of silver, twelve grains to the ounce. By this method we overcome the acute inflammation in about six weeks. Be careful not to get the solution into the urethra; it is very easy to get the solution into the bladder, which must be avoided by all means.

ORIGINAL ARTICLES.

EUPHTHALMIN: A NEW MYDRIATIC.

BY DR. B. TREUTLER.



THE AUTHOR has investigated the action of euphthalmin, the new mydriatic, in the Marburg University Eye Clinic, under the direction of Professor C. Hess. The new preparation is the hydrochloric acid salt of a mandelic derivative of *n*-methyl-vinyl-diaceton-alkamine. It is closely related to the new anæsthetic eucain, bearing the same relation to it chemically as does homatropine to tropa-cocaine.

Careful comparative experiments with the new mydriatic have enabled Dr. Treutler to publish the following conclusions:

(1) The instillation of euphthalmin solutions into the eye causes only very slight and temporary inconvenience.

(2) Euphthalmin is a powerful mydriatic. A 5 to 10 per cent. solution produces the maximum extension of the pupil in about the same time as 1 per cent. homatropine solution.

(3) The mydriatic action is less intensive and prompt with adults than with young people.

(4) As a mydriatic euphthalmin has the advantage over cocaine, that it is more powerful in action, and does not damage the corneal epithelium; on the other hand, mydriasis is somewhat slower in development.

(5) Euphthalmin affects the accommodation less than does homatropine.

(6) The disappearance both of mydriasis and of the paresis of the accommodation takes place much more quickly than after employment of homatropine.

(7) No unpleasant effects upon the organism have hitherto been observed.

The new preparation has, therefore, several important advantages over other mydriatics of brief activity, so that it invites extended employment in ophthalmological practice.—*Klin. Monatsblaetter fuer Augenheilkunde*, September, 1897.

EUPHTHALMIN MYDRIASIS.—At a meeting of the Medical Society of Giessen, on June 29, 1897, Dr. Vossius reported that a 2 per cent. solution of euphtalmin had been successfully employed for production of mydriasis. Two or three drops of the colorless solution in the eye produces a medium degree of mydriasis within twenty to thirty minutes, and disappears entirely in two or three hours. No pain nor other unpleasant effect follows the instillation, and the accommodation is unaffected. Euphtalmin is specially useful in ophthalmoscopic examinations, where the constricted pupil renders such an examination difficult in consequence of the temporary effect upon the pupils and the absence of disturbance of the accommodation.—*Deutsche Med. Wochenschrift*, No. 38, 1897.

GUNSHOT WOUND OF THE ABDOMEN—COELIOTOMY.

By WM. CLAY CARDWELL, M. D., of Carrollton, Ark.,
President of the Carroll County Medical Society.



ON MAY 29, 1897, 8 A. M., I was called to see Mr. L. Blanton, age twenty-three; single; physical condition excellent.

At 6 o'clock that morning, during a family quarrel, the young man's mother and sister were trying to take a 41-caliber pistol from him, when the pistol fired, inflicting a wound of the abdomen. This young man lived six miles from any town, and it was 9 o'clock when I arrived, about three hours after the injury. Upon examination I found that the ball penetrated the abdominal wall one and one-half inches to the left of the umbilicus, and ranged downward and backward, emerging through the right gluteal region, one inch from the median line and two and one-half inches from the anus.

The patient was suffering from pains in the chest; pulse 90; temperature normal; no hemorrhage from either external wound; but it was evident that internal hemorrhage was going on, from the extreme facial pallor and abdominal distention.

From the course the missile took, I was satisfied that great injury had been done to the abdominal viscera, and that an operation offered the only chance for the patient.

I called Drs. Poynor, Watkins and Kirkpatrick in consultation. During the time I had to wait for consultation I gave ergot and strychnine to counteract hemorrhage and shock. I catheterized the patient and found the urine normal, proving that the bladder and ureters had escaped injury. At noon the patient passed about one-half gallon of blood and feces from the bowels, proving that the intestines had been injured.

The consulting physicians arrived at 2 P. M., and after a brief consultation we agreed to operate, and by 3 P. M. we were ready, after having administered one-thirtieth grain strychnia, hypodermatically and given chloroform as an anæsthetic. The strictest antiseptic precautions were taken in all our preparations for operation. The patient's condition had gradually grown worse and his pulse was 120 when the operation was commenced. I made a longitudinal incision through the belly of the left rectus muscle, including the wound made by the ball. On opening the abdominal cavity we found it filled with clots and feces and an active hemorrhage going on at that time. After flushing the cavity with hot normal salt solution we found a wound in the small intestine, through which I could pass my little finger. It was closed by a Lembert suture of fine silk. We continued pulling out the small intestine, replacing that portion of it which had been examined, and closing perforations until we closed fourteen large openings in the small intestine. By this time the patient was in collapse, but by using strychnia hypodermatically and hot saline solutions freely in the abdominal cavity the patient soon rallied. We then re-examined the intestines carefully and found no more perforations. We could not determine the injury done by the missile in passing through the pelvis, but being certain that the bladder and ureters were free, there could be nothing else of consequence injured, except the rectum and blood-vessels of the pelvis. The abdominal cavity was cleansed as carefully as possible and closed by silk-worm gut sutures. Drainage was provided for by a rubber drainage tube, which extended into the pelvis. The patient was placed in bed and soon recovered from the anæsthetic, but his condition was very grave; pulse almost imperceptible.

During the operation the exposed intestines were kept warm by hot sterile cloths. There was considerable peritonitis around the intestinal wounds, and a slight general peritonitis. The operation lasted two hours. We ordered strychnia given during the night, hot water bottles to supply warmth, and morphia for pain.

At 9 A. M. next day I found the patient cheerful, but his pulse was thready and very rapid; great abdominal tenderness on left side; intense thirst and facial expression bad; considerable discharge of serous fluid through the drainage tube. The prognosis at this hour was very grave. The patient died at noon of the same day, thirty hours after the injury.

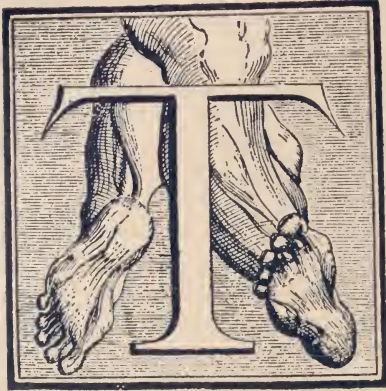
I feel that we did right in operating on this man, for there was unmistakable evidence of intestinal injury before the abdominal cavity was opened, and the patient would surely have died without an operation.

Wyeth, speaking in favor of operating in penetrating wounds of the abdomen, says: "If the alimentary canal is opened, death is almost inevitable. The few recorded cases of recovery form such an infinitesimal proportion of the whole, that they should carry no weight against interference."

THE YELLOW FEVER EPIDEMIC.

By JOHN GUITERAS, M. D., of Philadelphia,

Professor of Pathology in the University of Pennsylvania.



THE EPIDEMIC of yellow fever this year in the South has been an unusual one, because of its mildness and because of the late date of its commencement. Usually these epidemics reach their height during the first half of September. This year the existence of the disease first became known about this time. Though the disease spread over a wide extent of territory, from the Florida boundary to Galveston, Texas, yet the daily mortality in the whole district was below what it has been in former epidemics in a single city. Yellow

fever has undoubtedly presented a milder type in this country since the epidemic of 1887 in Key West. In part I attribute this to more precise methods of diagnosis that enable us to recognize mild cases of the disease that were excluded from the statistics of former epidemics.

Yellow fever is carried, in the great majority of cases, by individuals who sicken with the disease after arriving at their new place of residence. If the case be not recognized and properly handled, the house becomes infected and visitors contract the disease, or it spreads to the nearest house. This is very likely to happen if the case is a mild one and is not recognized. On the other hand, I do not hesitate to say that a case properly labeled yellow fever can be introduced during the summer in a southern city without the slightest danger to the community.

We do not know yet the source of introduction of the disease this summer. At first it appeared as if the disease had been introduced through Ocean Springs. This, however, would be very unusual, and we shall have to reject this theory unless it be very clearly proven. Ocean Springs is a small summer resort, and yellow fever is generally introduced through the large commercial cities in frequent intercourse with Cuba and other yellow fever centers. Yellow fever will occasionally slip past our best quarantine stations. We have now and then isolated imported cases in the sea-port cities of the South. These, however, are usually recognized and properly handled. The result is that the disease does not spread. An important object-lesson to the people of the South, one that would strengthen their confidence in the health authorities, is thereby lost, because to avoid alarm such cases are not given to the public.

I have said that the usual source from whence we get yellow fever in this country is Cuba. From 1693 to 1897 the disease has invaded this country in ninety-four different years. For eighty-two of these years we have proof, more or less complete, of importation, and in seventy-six of these the source of infection is to be found in the West Indies. By the West Indies, Cuba is generally meant; and as far as recent invasions are

concerned, Cuba is found always to be the focus of infection. The United States has long recognized this as the greatest source of danger. The United States Havana Yellow Fever Commission recommended the appointment of sanitary inspectors by this government to reside in Havana, because no reliance could be placed on bills of health and sanitary reports emanating from the Spanish authorities in Cuba. The attitude of that government toward yellow fever has always been one of criminal indifference.

When the yellow fever has been once introduced into our southern country, have we the adequate means to prevent its further spread? An appropriation is made by the national government for this purpose, and the United States Marine-Hospital Service is charged with the management of this fund. In my opinion, the money, as well as the authority invested in the marine-hospital service, is inadequate to an extreme degree to meet the requirements of the situation. This service has some men trained perfectly to meet the emergencies, and I know of no group of men more devoted to duty than they are and more deserving the thanks of the nation. But when the time comes for action these officers have to improvise nearly all the implements in their warfare against the invasion. The position is similar to that that this country would occupy if it were confronted by a foreign war and had only the officers, but no militia, and no standing army to form a nucleus of defense. The extent of the effort made by the marine hospital service to assist the several boards of health is marvelous, if we compare it with the means at the disposal of this government bureau and the authority it has to enforce the necessary measures for the prevention of the spread of an epidemic.

DODGING DEATH.

By FAYETTE C. EWING, M. D., of St. Louis.



PROPOS of the sporadic yellow fever epidemic in the South, with its attenuated virus, and the extensive hegira, we see human nature at its worst.

The foolishness of it all!

Citing the city of New Orleans, with its population of three hundred thousand, as an object-lesson, there have been approximately one thousand cases and one hundred deaths, a mortality of ten per cent. The outbreak was not until fall, and there was never any real danger of an extensive epidemic. One in three thousand of the entire population attacked, and one-third

of one per cent. have died. When we consider the great numbers that develop phthisis, and that fifteen per cent. of all the deaths that occur in this

country are due to that disease; that pneumonia, the most prevalent of serious acute diseases, has a mortality of often twenty per cent., and that the death-rate in some American cities, from all causes, reaches the enormous ratio annually of twenty-five in every thousand, we have an illustration of the folly of this fear. We have named only two of the thousand ills that flesh is heir to, some one of which will surely close our mortal account; and when we figure on the chances in the game of life and death, this helter-skelter flight becomes a mere shuffle against loaded dice; a juggle with the inevitable; an attempt at playing hide-and-seek with the Lord's High Executioner, with a one-sided hiding.

The cravenness of it all!

Doctors in search of scientific facts driven back by bayonets. Every day, on every train, *out* of the jaws of death rode the six hundred. Well for the shot-gun brigade to corral the cowards.

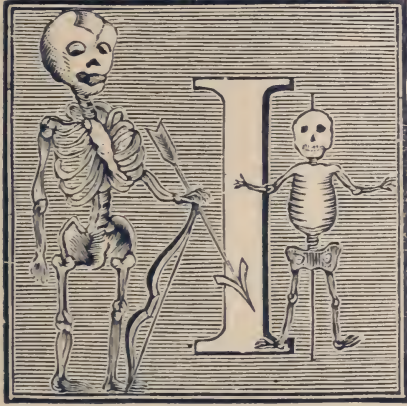
We read of a husband fleeing from his sick wife, and of mothers leaving their little ones to the care of hired hands. A man, ill with malaria, put off a train in a Kentucky town, refused a shelter, found refuge in a barn, where a mob of so-called human beings sought to burn him, and were prevented by the owner, who held them off with a rifle. The pastor of a fashionable church, a native of New England, in simple duty returned to his flock from his summer vacation. He caught the fever, recovered, and forthwith is held up as a hero. We pause to ask after the medical profession in many a fearful scourge: Who measures their actions at more than duty? Who heralds the heroes? When the exaggerated alarm was sounded this summer they stood "firm, like a stone wall." When the calls came they stood not upon the order of going, but went. Like Beauregard on Manassas' bloody field, leaping from their steeds among the stricken, by their action proclaimed: Brothers, we have come here to die with you, if need be. And some have fallen in the fight.

Reverently thankful are we for our medical martyrs. Living, they taught men how to die; dying, how to live.

Lactophenin is Perfectly Safe.—In his exhaustive chapter on tuberculosis in Wilson's "American Text-Book of Applied Therapeutics," Prof. James T. Whittaker, of Cincinnati, compares the antipyretics at various stages of treatment, and always speaks most favorably of lactophenin. Thus, in mentioning methods for lowering the temperature (p. 376), he says that salol is safer than acetanilid, antipyrin or phenacetin, "but, as it liberates carbolic acid in the intestine, it should not be given in any case of stasis of the kidney;" and then he adds: "Lactophenin, in the same dosage (5 to 7 grains), is efficacious and free from danger." To quiet pain (p. 384), "sometimes due to a toxic neuralgia," salol is safer than either phenacetin or antipyrin (the latter, in large doses, depressing the heart), "while lactophenin is a perfectly safe drug in the same dose (5 grains every two hours)." This view is in accord with the judgment of the many reporters, that lactophenin is the safest of all the newer antipyretics.

ELECTRO-THERAPEUTICS.*

By W. B. SPRAGUE, M. D., of Eureka Springs, Ark.



IN PRESENTING so comprehensive a subject to you it is not my intention to exhaust it, but to briefly and concisely outline the field of its usefulness at the present stage of its evolution. Although one of the most recent additions to our armamentarium, electricity already has a wider range of usefulness than any other remedy, as I shall attempt to show; and like most of the agents we now employ with scientific accuracy, it has passed through the stage of blind empiricism to a plane where every application may be made upon a rational basis, and every result explained upon physiological prin-

ciples. Thus, not only each known form of the electric current—the constant, the alternating, the induced, the sinusoidal and the convective—produces its individual influence upon the animal organism, but the manner of administration varies the results almost indefinitely, until the study of this branch of therapy is rapidly developing into a specialty which requires the most ardent and energetic effort on the part of those who wish to get the most that is possible from it.

From the constant or galvanic current, for instance, we may produce electrolysis, cataphoresis, electrotonus, catalysis, contractions or cauterly, at will. Then, again, electrolysis is positive or negative, according as the anode or cathode is made the active pole. The positive pole attracts the negative ions, or acid radicles, which coagulate albumen and produce an astringent effect on the adjacent tissues; thus positive electrolysis becomes valuable in the treatment of varicosities, nævi, aneurisms, phagedenic ulcerations, fungus endometritis, exuberant granulations, sub-involution, menorrhagia, etc. If the electrode be soluble in acids, as copper or zinc, some of the metal is dissolved, producing, for instance, oxychloride of copper, which is deposited not only on, but *in*, the tissues in the vicinity by the cataphoretic influence presently to be described. This is known as metallic electrolysis, and is of great value in the treatment of ulcer, fissure in ano, purulent endometritis, parasitic skin diseases, and numerous other conditions too numerous to mention, but which will occur readily to one following out this line of investigation.

At the negative pole, or cathode, the positive ions or alkaline bases congregate, and the effect is to liquefy the albumens and soften any tissue in the vicinity. Hence, its value in the treatment of stricture or other cicatricial deposits; in cosmetics (such as removal of superfluous hairs, non-vascular neoplasms, warty growths, etc.); in absorption of fibromata, etc. In the last-named instance, by liquefying of these abnormalities (retrograde metamorphosis), their absorption and removal on the part of the various organs becomes possible.

* Read before the Tri-County Medical Society, November 5, 1897.

Cataphoresis and anaphoresis (according as the direction of the current is direct or reversed) enter more or less into the results just detailed, but possess characteristics essentially distinct. Cataphoresis, that with which we have most to deal, is simply electro-endosmose. That the constant current of electricity greatly facilitates ordinary osmosis, or diffusion of fluids of different density through intervening porous septa, has been fully and repeatedly demonstrated. De la Rive, after numerous careful experiments, established the following law, to-wit: "The force with which a galvanic current transports a liquid through a porous partition from the positive to the negative wall is measured by a pressure which is directly proportional to the intensity of the current, to the electric resistance of the liquid, to the thickness of the porous partition, and inversely proportional to the surface of that partition." Endosmotic currents are constantly passing through the various tissues in the metabolic processes of the animal organism. These may be accelerated in accordance with the above law by the passage of a constant current of electricity in the direction of the endosmotic current, the direction of the electric current being always from the anode to the cathode, or from the positive to the negative. By virtue of this property of the electric current we may promote the absorption of cicatricial deposits and abnormal growths after they have been liquefied by negative electrolysis, as described before; cause absorption of pathological fluid deposits or accumulations in serous or synovial cavities, as in hydrocele, synovitis, etc.; stimulate excretions and secretions; and cause absorption of various medicines in solution, as cocaine or nascent solutions of copper and other metals, formed at the positive pole. It is probable that we may also cause the excretion of such foreign accumulations as lead, mercury, etc., from the system, through the skin, while the patient is immersed in an electric bath.

Electrotonus is the effect of electricity upon nerve tissue. The effect changes with the application of the different poles. Anelectrotonus is sedative and useful in neuralgia, nervous excitability and hyperæsthesia. Catelectrotonus is stimulant and irritating, and so useful in anæsthesia, functional inactivity and motor inexcitability.

Catalysis is a term introduced by Remak, long since, and was used to express all the phenomena occurring at a distance from and between the poles. Its definition is greatly limited since the various phenomena just detailed have been elucidated, and farther study may entirely obliterate it from the electro-therapeutists' vocabulary; but at present it seems necessary to retain it to express the final results upon the nutritive processes in the physiological laboratory and in clinical experience.

If we take a series of test-tubes, each containing a solution of pot. iodid. mixed with a solution of hydrated starch, and connect them by copper wires, we may, by making a constant circuit through this series, observe the blue discoloration produced by free iodine upon the hydrated starch, uniformly appearing at the anode of each cell in the series, showing that the effect of the current is produced, not only at the terminal poles of the circuit, but throughout the series.

Now, considering that every molecule in the circuit is capable of analysis into a positive and negative ion or radicle, which is undeniable, it is easy from this demonstration to conceive that when the anode attracts

the anion of a molecule the cation will attract the anion of the next molecule, and so on throughout the series, the last cation being free to satisfy the affinity of the terminal cathode. We can thus better appreciate the possibility of each and all the properties of a galvanic current being manifested upon and influencing the chemical and physiological changes constantly occurring in the metabolism of the body, in each and every molecule included in the circuit. The restoration to its proper size of an atrophied muscle, the improved tonicity of a dilated stomach or a prolapsed rectum or uterus; the development of an infantile womb in the adult female, and consequent cure of dysmenorrhœa or amenorrhœa, are all thus partially explained.

The contractile effect of electricity upon muscular fiber is too well known to need demonstration or explanation. Both voluntary and involuntary muscles respond readily to the make and break of a constant current; the latter much more slowly than the former, however, as is its nature. Thus, where active or voluntary exercise is, for any reason, insufficient or impossible, we may substitute passive or involuntary motion, and thus maintain or restore both the function and nutrition of an organ or part. In paralysis; in dilatation of stomach, heart or bladder; in constipation or indigestion due to deficient peristalsis; in deficient circulation of the blood or lymph; in subinvolution; in all these and in many other conditions, the indication is to avail ourselves of this property of electricity, as also in differentiating different forms of muscular and nerve degeneration. If the current be sufficiently intense, molecular life is destroyed and we have a cauterizing effect. This effect can be maintained for any desired length of time, through even the thinnest platinum blade, making the current invaluable in various surgical operations, such as the removal of polypi, nævi, epithelioma, caruncle, and other morbid growths; in opening certain cysts, furuncles and abscesses; in treating follicular tonsillitis and pharyngitis, and in the removal of all malignant growths, particularly of the pelvic viscera.

All of these effects are produced by the constant current. Many of them, and other effects, are produced by the other currents, but time forbids any further detail in this direction. Suffice to say that each current is useful and sometimes superior to any other therapeutic measure; as, for instance the sinusoidal current for sedative or muscular-tonic effect, or the high-frequency current, of which so much is now being written, to get the highest degree of electro-tonic influence.

It will be observed from this delineation that electricity seems hardly at all adapted to the treatment of acute or inflammatory conditions; while, on the other hand, there are few chronic diseases but may be more or less alleviated by a skillful use of the remedy. Then why is it not more universally used? Any drug that would be indicated in all these various conditions would be found in constant and universal demand! The reasons are several.

In the first place, to become so familiar with electrical apparatus as to be able to control its many vagaries requires long time and patience. So that many eminent surgeons will provide themselves with the most expensive outfit, find it fail them in an emergency, and forever after doom said outfit to outer darkness, loudly declaring the inutility of electricity. But it is

perfectly evident that skill and dexterity in the use of the *armamenta* is the first essential and cannot be dispensed with.

Then the time required in the proper administration of the remedy is not inconsiderable, and so it is excluded by the "busy practitioner." So it comes that the agent is chiefly used in sanitariums, where chronic invalids congregate, and by electrical specialists.

That this is so is, perhaps, not so much to be deplored as might at first thought appear. That a sanitarium or sanatorium is the ideal place to treat chronic invalidism is rapidly gaining universal recognition from the medical profession as well as from the lay public. That response to any therapeutic measure is favored by suitable surroundings and conditions has never been disputed, and the freedom from the ordinary cares and irritations of home life, and the soothing and encouraging influences which should prevail in a sanitarium, together with the careful supervision of diet, exercise and other habits, give the physician great advantages. But, if possible, still more important are the advantages of pure water, pure air, genial climate and favorable altitude which a sanatorium should afford. As members of the Tri-County Medical Society we can congratulate ourselves on having, at Eureka Springs, one of the best sanatoriums in the world. Certainly its water is unsurpassed, its air is pure, its climate is equable, and the altitude is right for the average chronic invalid. What more could be desired? For many of them, a first-class sanitarium.

There are sanitariums that are not located in sanatoriums, and many sanatoriums have no sanitariums. The ideal place for chronic invalids is a combination of the two. These words are often used as synonyms, but improperly so, I think. Sanatorium comes from the Latin word *sanator*,—one who heals, hence means any place or location specially conducive to health; while sanitarium is from *sanitas*—health or soundness of body, and is, or should be, a place where not only health is restored, but all things pertaining to health are taught and practiced.

Pardon, if you please, this seeming digression. It seemed to me not inappropriate under this head to specify the most favorable conditions under which electro-therapeutics may be practiced. I have, myself, observed superior results from the same administrations since locating at Eureka Springs to those obtained in a city practice.

Ferratin in Anemic Dyspepsias.—Dr. Elbridge G. Cutler, of Boston, in a very excellent paper entitled, "General Remarks on Gastric Dyspepsia," read before the Massachusetts Medical Society, June 8, 1897, and published in the *Boston Medical and Surgical Journal*, September 9, 1897, advises the use of ferratin to increase the hemoglobin. In examining the patient, "the relation or dependence of dyspeptic conditions on other local diseases or general disturbances" should be found. The lungs and the urine should be examined weekly and the patient weighed; and if diet, control of daily life, etc., do not increase the hemoglobin, then ferratin should be used to aid the other measures.

A SYSTEM TO TEACH GYNÆCOLOGY.

By BYRON ROBINSON, B. S., M. D., of Chicago, Illinois,

Professor in the Chicago Post-Graduate School of Gynæcology and Abdominal Surgery;
 Professor of Gynæcology in the Harvey Medical College and the Illinois Medical
 College; Gynæcologist to the Woman's Charity Hospital, and Con-
 sulting Surgeon to the Mary Thompson Hospital for
 Women and Children.



FOR THE past seventeen years I have pursued carefully, as a special study, gynæcology and abdominal surgery. In many ways the first years of gynæcology were not what they are now. Few knew much about it, and still fewer knew anything about the grand and successful gynæcologic surgery of Lawson Tait. But the knowledge quickly spread and gynæcology has now become a well-recognized special department of medicine.

But gynæcology, in its dignified sense, which means to correctly diagnose disease and operate successfully, is difficult to teach.

A gynæcologic clinic conducted systematically is rare and difficult of access. For at least ten years I have been attempting to develop a system of practical gynæcologic examinations, by which the examiner could get the most in the shortest period of time. I have taught two kinds of classes, the under-graduate and post-graduate. The difficulties are that both classes are nearly all deficient in practical anatomy; hence, much time is lost in recalling the essential features of location and structure. A second very great misfortune with the post-graduate is that he generally wants to operate long before he is even able to make a correct diagnosis. This view of the matter induces him to neglect anatomy and diagnosis.

I have employed two systems of teaching:

1. *Subjective*—Historical Landmarks in Gynæcology. They are founded on physiology, function and infection.
2. *Objective*—Anatomy and Pathology. This is the physical diagnosis made by the hands of the pupil, and is independent of the patient's statements.

The first division is important to under-graduates, as it serves to instruct as to the events in the functional and clinical life of women. These landmarks are:

1. Menstruation—

{	Age.
	Duration.
	Regularity.
	Pain.
2. Labor—Infection.
3. Abortion—Infection.
4. Discharges—

{	White.
	Yellow.
	Green.

5. Abdominal Enlargements— $\left\{ \begin{array}{l} \text{Fat.} \\ \text{Ascites.} \\ \text{Bloating.} \end{array} \right.$
6. Complaint—Pain in $\left\{ \begin{array}{l} \text{Back.} \\ \text{Head.} \\ \text{Stomach.} \end{array} \right.$

In quizzing the women for historical data, these are natural landmarks of function. *Menstruation* is one of the first functions of woman. It is important to know the *age* at which a woman began her first function, as late menstruation may mean non-development of the genitals—infantile uterus, or inflammatory process; both indicating sterility. Late menstruation tends to early menopause. Early menstruation means excessively developed genitals and late menopause. *Irregularity* means little, as most girls are irregular for over a year. The *duration* of the flow is significant, as a woman should flow only three to four days. A six-day flow may mean excessively developed genitals, and portends early genital disorders. *Pain*, dysmenorrhœa, at the monthly means nearly always metritis. Thus, menstruation, woman's first function, has four significant questions and vast interpretations from them may be made.

The second function of women is *labor*. What we wish to know is, was she infected at any labor? This is mainly found out by asking her how long she was in bed after any labor. If women lie in bed two weeks or more at labors or abortion they are likely infected.

The third function of women—in the landmarks, a broken one—is, has she had an *abortion*, and was she infected? We must find how long she lay in bed after the abortion. Abortion is worse than labor, on account of deficient drainage and infection. The os is never ready for an abortion, but is always ready for labor. At abortion the os is paralyzed by trauma and stands open for a few days, when infection can enter. After a few days the os recovers and closes up on the contained infection (placenta), preventing free drainage, whence the tubes become the sewers and the pelvic peritoneum the cess-pool. If the woman was infected at the abortion, she will generally lie in bed a few days extra. It is astonishing to observe how many women date their illness from a labor or an abortion, when from evident causes the three great germs, man's life-long enemies—the gonococcus, streptococcus and staphylococcus—run riot in growth and localities.

A fourth landmark to inquire into is, has the woman had a *vaginal discharge*? All women have a white discharge, but it may be absorbed before it appears at the vulva. Has she a yellow discharge, it means pus, infection. Of course, the discharge may come from the urethra, vulvo-vaginal gland, but it is likely from the endometrium, which has become infected. Has she a green discharge, it is from the bacillus pyocyanus. Such questions induce the student to think of cause and effect.

A fifth question, has she a *tumor*?

The tumor may be fat, hence it will be constant. It may be ascites, when it will vary or disappear; or it may be bloating or indigestion, gases. Women will complain of pain generally in the back, stomach and head. This local triumvirate of pain is impressive. The details, however, are of little use. The pain in the back is direct from dragging and pressure on

the hypogastric and ovarian plexuses and the third and fourth sacral nerves. The pain in the stomach and head is reflex as well as direct.

Thus we have here a skeleton, a system or method, by which especially the under-graduate may learn to think along gynæcologic lines. The student must learn what function is, and the meaning of infection and inflammatory processes.

Remember, that sexual histories are notoriously false. In sexual histories the wise gynæcologist always makes intra-cranial decisions and conclusions.

We now pass to the second division of our system of gynæcology, the *objective* one; the one lying in the domain of physical facts—the things we learn to feel and see. It rests chiefly on what a bimanual examination reveals. It is independent of the woman's statements. It is all contained in anatomy and pathology. Woe unto him that knoweth not anatomy, for on it rests pathology. It is purely a practical system. We first put the woman on a table and flex the thighs on the belly and the legs on the thighs—all to relax the psoas muscles so that the external hand may press down into the pelvis. The anatomy of the external genitals may now be inspected, if required. Always use one finger in the vagina, in order to secure room for delicate feeling.

The first great act in the drama is to find the os. Now, if the os be found at right angles to the index finger, *i. e.*, perpendicular to the axis of the vagina, it is normal in position. If the os be found parallel to the vagina, it is pathologic in position. This includes all that is required as to positions of the os. The os assumes, however, two pathologic positions, *viz.*: one parallel to the vaginal axis and one at varying angles to the anterior vaginal wall, as in extreme retroflexion or version.

The second great act in the drama is to locate the fundus of the uterus. Here is the rub that tests the gynæcologist. First, remember the os, if it is in normal position, *i. e.*, perpendicular to the axis of the vagina, the fundus will be in normal position in nearly all cases. If the os be in pathologic position, *i. e.*, parallel to the vagina, the fundus is always in a pathologic position, dislocated. Now, the pathologic position of the fundus nearly always means version, flexion or peritoneal exudates. Hence, a pathologic position of the os, *i. e.*, parallel to the vaginal axis, indicates that the fundus will lie forward, upward or backward.

Now arises the oft-repeated question: What is the normal position of the uterus? The answer is distinct and easily understood. The uterus is in its normal position when it is perfectly movable. A testicle comes under the same rule. A fixed uterus is a dislocated one. In general, the uterus is fixed by two factors, *viz.*: its own stiff, rigid, metritic walls or peritonic exudates. Here we should impress on the pupil four distinct pathologic positions, *viz.*:

1. Anteversion is where the uterus lies extended forward and is abnormally fixed.
2. Retroversion is where the uterus lies extended backward and is abnormally fixed.
3. Anteflexion is where the uterus is bent on its anterior surface and is abnormally fixed.

4. Retroflexion is where the uterus is bent on its posterior surface and is abnormally fixed.

Never forgetting that a fixed uterus is a dislocated one, and that the perfectly movable uterus is the one in normal position.

There are two ways to locate the fundus. One is to place the finger against the cervix and with the other hand on the abdomen attempt to palpate the uterus between the hands. By bobbing the cervix upward against the abdominal wall, the external hand feels and locates the fundus. Another method is to pass the index finger along the front surface of the uterus and feel for its direction. The same process may be repeated along the sides or posterior surface; one simply feels by the walls the direction assumed by the uterus.

Now, having located the position of the os (normal and pathologic) and the fundus of the uterus (normal—mobile; pathologic—fixed), we come to the third great act in the drama, *i. e.*, the location of the appendages. This is done by passing the index finger into the vagina well behind the broad ligament, and then with the other hand on the abdomen try to palpate the tube and ovary. The finger must go well back in Douglas' cul-de-sac, behind the broad ligament. I have employed this system with many post-graduate doctors, and it seems to impress them well. The gynecologists soon learn to avoid all, or almost all, subjective systems which depend on statements of patients. He soon learns to rely on anatomy and pathology as revealed by bimanual examination.

This system, then, consists, first, in eliciting clinical facts from the patients' life, as menstruation, labor, abortion, discharge and tumors. Second, it consists in locating the cervix (normal or pathologic), the fundus (normal or pathologic); and, finally, of locating the appendages (normal or pathologic). It consists in discipline in bimanual examination. The essentials of success in the system are:

1. A knowledge of anatomy.
2. A knowledge of pathology.
3. Bimanual examination with one finger (only) in the vagina.
4. Two gentle hands, so that the woman may not be hurt in the least, nor the muscles (psoas and abdominal) insulted by trauma, or they will resent by tension.

A successful bimanual examination must be done so gently that no muscle is put on a tension. It is useless, cruel and unscientific to hurt women in examination.

Southern California.—We desire to call the attention of physicians to the resumption of through winter service to California by the Wabash Railroad. We offer many attractions to those who are feeble or in ill health, namely: luxurious through sleepers from St. Louis to Los Angeles, also a library car (provided with easy chairs and current standard literature) for day use, and a nicely-appointed dining car. The fast time of last season has been slightly accelerated and the trip from St. Louis to Los Angeles can now be made in about two and three-fourth days. Our through service is operated twice a week, leaving St. Louis Wednesday and Saturday nights.

C. S. CRANE,

General Passenger and Ticket Agent, St. Louis, Mo.

THE IMPORTANCE OF RECTAL EXAMINATIONS IN LIFE INSURANCE.

By R. D. MASON, M. D., of Missouri Valley, Iowa,

Lecturer on Rectal Diseases in Creighton Medical College, Omaha, Neb.



THE PHYSICIAN who wishes to be thorough in his examinations of applicants for life insurance there are certain cases that are of the greatest importance, especially when viewed from the standpoint of the company's interests.

I refer to the existence of rectal cancer, ulcer, syphilis, stricture and fistula. It is well known to any one who does much rectal surgery that nearly all rectal affections are called by the laity "piles," and when the question: "Have you had piles, fistula, or any disease of the rectum?" is reached, in the course of the examination,

it is not at all uncommon for the applicant to answer that he is "troubled slightly with piles." His so-called piles may consist of the discharge of blood, or of a mixture of mucus, pus and blood, indicating ulceration, cancer or stricture; but the examiner will record the answer as given by the applicant, or at the suggestion of the agent, if he happens to be present; will answer the question in the negative, as "it is of no importance and makes the examination look bad."

For the benefit of the company about to assume the risk, such cases should be submitted to a thorough and careful rectal examination. The importance of a thorough physical examination is of so much significance that most insurance companies use great care to secure the services of competent examiners, that no risk below a certain physical standard may be admitted. The lungs, heart and kidneys are submitted to thorough and careful examination, while the last four inches of the intestinal canal, which is more apt to be diseased than any of them, has no attention paid to it.

It is impossible to get exact data as to the number of deaths due to causes that might have been avoided by a careful rectal examination, but in a list of 354 deaths, as reported to one of our large assessment companies, I find the following causes given that bear closely on this subject:

Cancer (location not given)	11
Phthisis pulmonalis	54
Cancer of rectum.....	2
Ulceration of rectum.....	2
Consumption of bowels.....	1
Dysentery.....	1
	<hr/>

71

The average age of these seventy-one parties is about forty years, and many of them had taken their insurance less than a year before death. Of course, the cancers not located were probably, most of them, in other por-

tions of the body than the rectum; and it is not likely that more than a very small per cent. of the cases of pulmonary phthisis could have been detected by a rectal examination at the time the insurance was taken. Still, it is that small per cent. that is under consideration; and in the list given there are six strictly rectal diseases that could, in all probability, have been diagnosed at the time the examination was made and the company saved considerable loss.

It is well known that many cases of rectal cancer, ulceration, stricture and so forth, are never diagnosed, but are treated for other troubles; and it is likely that some of the deaths that were given as due to other causes, as abdominal tumors, perforation of the bowel, and several other rather indefinite troubles in this vicinity, were, in reality, due to some one of the above-named diseases.

When these facts are considered, it is readily seen that at least part of the diseases which caused death in the list given could, by proper care, have been detected at the time the insurance was asked for. Even if it is admitted that only one could have been rejected on account of the beginning of a fatal disease, it proves the argument for which I am contending, for no company should be made to assume a risk that is known to be unsafe. Both the company and the applicant have rights that should receive equal and impartial attention at the hands of the examining physician.

I wish to report a few cases which will illustrate fully my views of this matter.

Mr. W., age thirty-seven, applied for insurance in one of our old line companies. His family history was good, with the exception of his mother, who died of phthisis, and a sister who died from some cause following confinement, not very satisfactorily explained, but as she was ill two months, I looked upon her case with suspicion. Mr. W. himself was in perfect health in every way, with the exception that he was "troubled a little with piles." Upon examining the rectum I could not find any hemorrhoids or, in fact, much of any disease other than a very slight moisture, which seemed to come from a fistula; but by the most painstaking effort I could find no fistulous opening. Still, the tissues around the anus did not feel or look healthy, and I declined to recommend the risk for a period of three months, which time, I thought, would develop any diseased condition present to a point where it could be detected. The agent who solicited the risk was not satisfied with this, as it caused the loss of a good commission to him, so he took the applicant to another examiner, who passed him, entirely ignoring the rectal trouble. In less than three months a tubercular fistula made its appearance, and in less than a year and a half the applicant died from general tuberculosis.

In speaking of cancer of the rectum, Kelsey, in his last work on diseases of the rectum and pelvis, says: "It is often astonishing to the surgeon to meet with an advanced case of scirrhus, in which the caliber of the bowel is so nearly occluded as scarcely to admit the passage of the finger, and yet in which the patient has never had sufficient uneasiness to call for a direct rectal examination."

Dr. Matthews, in his work on rectal disease, relates the following case, which shows the importance of examination: "Mr. C., about forty-five

years old, came to me, at the suggestion of his physician, for an examination of his rectum. He remarked that his doctor was not sure that he had rectal disease, nor was he; yet, because of the fact that he strained at stool and passed a little blood and mucus, he thought it best to be examined. Placing him in Sims' position on a hard table, and in a good light, I carefully searched the rectum with a speculum, but could find no disease. Removing the instrument I inserted my finger and asked the patient to strain down, when I was enabled to explore the gut five or six inches. At the end of my finger I detected an indurated spot, which seemed to extend upward. Reasoning by exclusion, I could not imagine any other disease which could cause this hard, nodular, little tumor located at this spot. Although there was no gland involvement, I was thoroughly of the opinion that this man had incipient cancer. He was given treatment by injection, etc., and in a few days his symptoms cleared up, and there was no discharge of either blood or mucus, and no straining at stool. After this he took a long journey of about fifteen hundred miles, and upon his return he called at my office to say that he had entirely recovered. He had a rest from all bad symptoms for a month or six weeks. During this interim he applied for a policy of ten thousand dollars, passed the examination (no attention being paid to his rectum), and was insured. After awhile his condition grew worse; a discharge of blood and mucus was noticed; he began to emaciate; took on a bad color; and in less than six months perforation took place and he died of cancer."

The next disease that I wish to speak of is very important and not very uncommon, and, like those spoken of, is classed by the applicant as piles. This is *ulceration*. When we consider the following symptoms of the disease, as given by Kelsey, it is readily seen that an applicant who said he was troubled with piles would be passed without question by the average examiner, if application was made before the disease was too far advanced: "The earliest symptom is morning diarrhoea, and that of a peculiar character. The instant the patient gets out of bed he feels a most urgent desire to go to stool. What he passes is generally wind and some discharge resembling 'coffee grounds,' both in color and consistency; occasionally the discharge is like the 'white of an unboiled egg,' or a 'jelly fish,' more rarely there is matter. He in all probability has tenesmus, but does not feel relieved; there is something of a burning sensation, but not actual pain. Before he is dressed he very likely has to again seek the closet; this time he passes fecal matter, often lumpy, and occasionally smeared with blood. It may also happen that after breakfast, taking hot tea or coffee, the bowels will again act; after this he feels all right and goes about his business for the rest of the day, only perhaps occasionally being reminded that he has something wrong with his bowel. After this condition has lasted for some months, more or less, as influenced by the seat of the ulceration and the rapidity of its extension, the patient begins to have more burning pain after an evacuation; there is also greater straining and an increase in quantity of discharge from the bowel; there is now not so much jelly-like matter from the bowel, but more pus—more of the coffee-ground discharge and blood." * * *

"We need scarcely call attention to the extreme gravity of this condition or to the certainty with which, if untreated, and sometimes, indeed,

in spite of the best treatment, it will end either fatally or in stricture which will require the gravest surgical procedures for its relief. The picture is unfortunately a familiar one to every general practitioner; and a case of severe or extensive ulceration of the rectum is perhaps one which calls for as much skill in treatment as anything in the range of surgery."

I quote thus at length to show that this is quite a common affection and very slow and insidious in its attack; yet it is one that can be diagnosed by a careful examination, even in its earliest stages.

As illustrating the above condition I would cite the following case: Mr. B., age about forty, consulted me because he was "troubled with piles." He stated that he felt a little pain of a dull, burning character, and had some discharge of "white stuff," and occasionally the motions were "streaked with blood." It did not bother him much, but he thought he would see what I thought about it. He did not think it of enough importance to submit to an examination, even after I had explained to him the probable cause and result of his disease. He consulted another physician, who told him it was nothing that amounted to anything and gave him some medicine to take which would "make matters all right in a few days."

At this time Mr. B. was in good health except the trouble spoken of, and would have been accepted by nearly any company to whom he might have applied for insurance. Shortly after consulting me he moved to another town and I did not see him for several months, but one day he came into my office and he was so pale and emaciated that I scarcely knew him. He told me that he had lost fifty pounds in weight and his bowels were moving from ten to twenty times daily. His physician was treating him for intestinal consumption. He died soon after this.

There are many cases of chronic proctitis, or rectal catarrh, that are easily recognized if the proper methods of diagnosis are adopted and which usually yield promptly to treatment. These cases are quite common among men of middle age, especially those whose occupation is largely out of doors, where they are exposed to sudden changes of temperature. This condition is responsible for the large number of cases of chronic diarrhoea seen among our old soldiers and is directly due to the exposure and hardships incident to camp life, especially sitting and sleeping on damp, cold ground. Many of these cases die after only a few years of suffering from this disease, or with some other comparatively mild affection complicated with it; again, it may assume an ulcerative form and result in stricture or perforation and death.

There is a long period of time in most of these cases during which the disease is easily recognized but has not symptoms of sufficient severity to prevent an applicant from passing a satisfactory examination.

I believe all who will give the matter careful attention will agree with me that the conditions outlined are very important and deserve the serious and thoughtful attention of all examiners who have at heart the best interests of the company which they represent.

I do not wish to be understood as advocating a rectal examination in all applicants, but only in those where for any reason it seems to be indicated.

DERMOID CYST.*

By W. M. CATTO, M. D., of Decatur, Ill.



THE SUBJECT of dermoid cyst has been one of great interest to the profession ever since the recognition of these tumors.

This is due to their peculiar formation, location, and, above all, their mode of origin; about which last much wild speculation was indulged in when our knowledge of embryology was less than it is now.

They may be found in both sexes, and at any period of life from early infancy to old age.

Unlike most other tumors, dermoid cysts are *always* congenital.

They are so-called from the fact that the cyst-walls resemble skin and, indeed, have all the essential features of true skin. The outer surface is smooth, tense, shiny, similar in color and appearance to the external covering of a foetal head; the inner surface presenting the appearance of coarse skin, studded with hair, having hair follicles, sebaceous and sudoriparous glands.

Their contents are fatty and sebaceous matter, hair in greater or less abundance, cartilage, bone, teeth, and even gray brain matter. When bone is present, it is usually situated in the cyst-wall, and more or less covered with the derma.

As to the *origin* of this class of tumors many different theories have been advanced, some of which are wholly untenable: *e. g.*, that in case of ovarian dermoid it is the product of a blighted ovarian conception.

Some claim that they come from the distention of the cavity of some persistent foetal structure which normally should have been obliterated. Others, that they are formed by the inclusion of a blighted ovum in the ovary or testicle.

The most probable theory yet advanced, and the one generally accepted, is that they are due to the inclusion of a portion of the epiblast within the mesoblast. This is further borne out by the fact that the external ones are so frequently found about the face and head, where fissures exist in the embryo, and that they are formed in connection with imperfectly-closed branchial fissures.

As to location, they are found both externally and internally and in various situations; the points of predilection being the outer angle of the orbit, over the root of the nose, the testicles, scrotum and ovaries. Less frequently they are found in the liver, in the vulva, or in the margin of the cornea. They may be connected with the spine at the sacral region, where they may be mistaken for spina-bifida.

* Read before the Central District Medical Society, at Taylorville, Ill.

When situated on the face or head, processes from the tumor may extend into the orbit or even into the cranial cavity.

In this situation they are found most frequently at the outer angle of the orbit; less often on the front of the frontal bone, and very *rarely* over the other bones of the cranial vault.

These external tumors grow very slowly, rarely attaining a greater diameter than one inch.

I saw one of these, a few weeks ago, in a boy of twelve years: it was situated at the outer angle of the orbit, impinging somewhat upon the upper eyelid; but as it seemed stationary so far as growth was concerned, and was giving no inconvenience, operation was not advised.

They are often difficult to remove; they may appear superficial, but may extend to a dangerous depth. When small and giving no special trouble, they are as well let alone; and the more especially is this true if they have certainly perforated the skull.

When a dermoid is situated in the eye, it is usually at the cornea-scleral junction, is characterized by a slight indurated tumor, distinctly cystic in character and containing a small quantity of yellow hair.

One such case came under my observation a number of years ago, occurring in the practice of Dr. C. J. Lundy, of Detroit. In this case the cyst was located in the sclerotic, was entirely distinct from the cornea, and was removed with difficulty, owing to the thinness of its walls.

Situated in the sacral region, a dermoid cyst may be mistaken for spina-bifida; but there is no reason why it should ever be confounded with pilonidal sinus, or hair nest, occurring in this vicinity in the adult, although a discussion regarding their identity arose at the last meeting of the Illinois State Medical Society, over a paper read by Dr. D. W. Graham, of Chicago, upon the latter subject.

Dermoid cyst of the scrotum is usually associated with the right testicle.

Goodsir reports a case of dermoid of the right testicle containing skin, hair and cartilage.

Marshall removed a testicle as large as an ostrich egg, containing within the cyst much oily matter and foetal remains.

Velpéau excised one from the scrotum which contained all the elements of a foetus. He claimed that the foetal remains were first in the abdomen and accompanied the testicle in its descent into the scrotum.

Vernéil, in 1855, collected a history of ten cases in which were skin, cartilage and gray brain matter. He was of the opinion that the inclusion was extra-testicular.

Paget considers dermoid of the testicle the result of great formative power during foetal or in the earliest extra-uterine period of life.

Klebs and Kocher believe that when *well-marked* parts of the body are found in a dermoid cyst there is inclusion of a second germ, but that when isolated or imperfect parts are found, it is due to the grafting of the germ of such tissue *onto* the rudimentary testicle.

Not all cases of dermoid in the scrotum are connected with the testicle.

Boeckel reports a case the size of a hen's egg enclosed in a pouch constituted of the deep layers of the scrotum and entirely distinct from the testicle.

Labbé, in 1858, reported a case occurring in a boy of fourteen, in which the tumor was implanted in the epididymis, the gland tissue being quite healthy and distinct from it. This tumor contained, in addition to all the structures usually found in a dermoid, unstriped muscular fiber, papillæ and villi, rendering it probable that part of the intestine was here represented. The arytenoid cartilages could be easily made out; these with the intestine could originate only from the internal leaf of the blastoderm.

Dermoid cysts of the ovary are always congenital and may be found at any period from birth to old age; frequently they are small and may remain unnoticed. They often remain dormant until puberty, when they may begin to grow until they become as large as an orange, and less frequently as large as a foetal head.

Mears, of Philadelphia, removed one successfully at six and one-half, and Spencer Wells one at eight years of age. I have seen one in a woman at the age of sixty-three years.

They constitute about three and one-half per cent. of ovarian tumors *removed*, although they probably make up a greater percentage of the actual number of ovarian tumors, as many of them, owing to their small size, and to the fact that they cause no special inconvenience, are not removed.

They, however, grow larger here than in any other situation; their contents are similar to those of like tumors in other regions of the body; viz.: hair, adipose and sebaceous matter, skin, bones, and teeth, as many as three hundred of the latter having been taken from a single tumor. These teeth, by the way, are scarcely ever found to be perfectly formed.

Of the specimens of dermoid cyst I present here to-day, the first and smaller one is of interest from its size and location.

June 18, 1896, Miss W., æt. 18, a resident of this city (Taylorville), came to me to have what she termed a "wen" removed. This growth had the following history: At birth, or during very early infancy, a small tumor was noticed on the head near the crown. It did not grow large enough to cause her any annoyance until she was about fifteen years old, when it began to increase in size and grew until she could not dress her hair so as to hide it. When I saw her the tumor was as large as an ordinary base-ball, distinctly pear-shaped, and evidently dipping into what had constituted the posterior fontanelle.

It was easily made out to be a dermoid from the tense, semi-fluctuating feel and the evident presence of something akin to bony matter in its interior.

Some difficulty was experienced during its removal, owing to the very profuse hemorrhage encountered, which, by the way, is a common characteristic of external dermoids; and, later, upon the discovery that the base or pedicle dipped down between the junction of the sagittal sutures and became intra-cranial. This last difficulty was overcome by dissecting down as closely as possible, making tension, and after securely ligating the pedicle, it was cut off close.

The redundant tissue of the scalp was cut away, the parts sutured, and the wound healed without noticeable incident.

Her family physician tells me she has experienced no trouble since.

You will note that the specimen is large for this situation, and contains a considerable quantity of hair of the characteristic appearance, the wall being composed of skin, with some cartilaginous material imbedded in it.

The second and much larger specimen was removed in the case of Miss R. K., æt. 27, unmarried. I first discovered the tumor, an ovarian dermoid, upon being called to treat her for some illness, the precise nature of which I have forgotten, but in the course of which I had occasion to examine the abdomen.

The tumor was at that time about the size of a pregnant uterus between the fourth and fifth month, but lay more to the right of the median line. The patient, who was fleshy, was unaware of its presence, and as it had given her no trouble, demurred at my suggestion that it should be removed.

She did not come under my observation again for eighteen months, when I was called to prescribe for her again. She was suffering great pain in the right hip and thigh—could walk, but with difficulty, and appeared ill. Concluding that the pain was due to intra-pelvic pressure from the tumor, I determined upon its removal.

I operated on January 13th, assisted by Dr. W. J. Chenowith, of Decatur, and Dr. Fithian, of Springfield.

The only difficulty experienced in the operation was in the close attachment of the tumor to the right horn of the uterus, this being so close that it was scarcely possible to ligate or avoid removing a part of the uterine body. The tumor, whose cyst-wall and part of the contents of which I here present, weighed about six pounds. It was about the size and shape of a two-quart Mason jar, the contents being sebaceous-matter, fat, hair, bone and a molar tooth, the two latter being attached to the wall. The hair here presented, though not an inconsiderable quantity, is perhaps not more than two-thirds of the entire amount present, the remainder having been thrown away while this was being separated from the sebaceous matter through which it was mingled.

Mundé reports a case of dermoid cyst from which he removed a switch of hair five feet long. I do not know how this specimen would compare with that in amount by weight, but I find it to be six feet four inches long by actual measurement.

Bryson's Symptom.—Hugh T. Patrick, of Chicago, one of the most distinguished members of the Tri-State Medical Society of Iowa, Illinois and Missouri, maintains that he has knocked out the Bryson symptom in exophthalmic goitre, showing by a study of forty cases that the diminished chest expansion frequently found in this disease is in no sense pathognomonic, but is simply an expression of the general myelasthenia which he claims is always present therein.

The Senn Prize.—A medal, to be known as the Nicholas Senn Prize Medal, will be awarded at the annual meeting in 1898, to that member of the American Medical Association who shall present the best essay upon some surgical subject.

ZONA.

By A. H. OHMANN-DUMESNIL, of St. Louis.



AMONG the diseases of the skin which are easily recognized, even by the laity, may be reckoned zona, or, as it is perhaps better known by the name of, herpes zoster. It is the "shingles" of the old granny, and nearly every one has had an opportunity of observing one or more cases of the affection. It is called an acute disease of the skin and is included by the majority of writers in the inflammatory class. There is certainly some reason to question this, as it is primarily due to some organic alteration in the nerves. This is no doubt the reason why zona in adults is invariably

preceded by premonitory symptoms which manifest themselves in the form of a neuralgia which is of an apparently intractable character, as it does not yield to any form of medication addressed to the alleviation of the pain. This neuralgia is of a peculiar character in this way, that it affects the area which subsequently becomes the seat of the affection. After the neuralgia has existed for some time, for days in some cases, the eruption makes its appearance. This eruption of objective lesions, however, is by no means a signal of the departure of the subjective symptoms. The neuralgia, malaise, and other untoward symptoms may not only be present, but generally persist for some time. In fact, it is this pain which causes the greater part of the complaints made by patients. The constant neuralgia is not only of a very marked character, but is inclined to be persistent. It is generally said that the prodromic neuralgia exists about two weeks before the appearance of the eruption, but this cannot be regarded as a fixed rule, for it may not have been felt for a longer period than a few days before the cutaneous symptoms appear. At all events, the period is of a sufficient length to make quite a marked impression upon the general condition of the one subject to the trouble.

The eruption is one which is easily recognized, as a rule. The laity are all very quick to know it and have a good idea of its subjective symptoms and course. And yet, unless the lesions and their grouping be well understood, mistakes in diagnosis, even by physicians, are apt to occur. The eruption first appears in the form of an erythema or reddening of the skin, more or less limited in its outlines. The color is quite a bright red and there is tingling and smarting of the skin experienced in addition to the neuralgia. The distribution of the erythema should always give rise to suspicions of the true nature of the disease, as it occupies the portion of skin which will later on be covered by the characteristic lesions and which will be described further on. Succeeding the erythema there may be noted

the appearance of a crop of vesicles arranged in groups. Each group consists of from three to twelve or more vesicles which vary in size from a millet-seed to a split pea. As the lesions grow older they also grow larger and new crops successively appear one after the other. One fact to be noted is the peculiarity of the grouping of the vesicles, which is distinctly herpetic in character and partakes a great deal in the nature of herpes. In fact, the French have applied a generic name to all of this group of vesicular distribution in the herpetides, and even contend that there exists a herpetic diathesis. Another peculiar fact in connection with the eruption of zona is that the groups of vesicles are not totally isolated. They are in a manner joined to one another by scattered vesicles occurring here and there, as if an effort had been made to produce new patches and had proven abortive. A glance at almost any good picture of zona will show this in a very plain and marked manner. The vesicles in zona are filled with a clear serum, and each lesion is surrounded by a bright-red areola; so that, upon a mere superficial examination, the eruption looks as if the translucent vesicles had been implanted upon a bright-red field, whilst closer examination will reveal a distinct areola around each one, the periphery of the areola being not so bright as that portion immediately around the vesicle.

One of the most interesting features in connection with zona is its distribution. This is valuable to the observer as well, as it enables him to recognize the disease and formulate a diagnosis much more easily than he could otherwise, and it will often keep him from falling into the pitfall of being an alarmist without any adequate reason for so doing. The distribution of the lesions is such that the groups of vesicles lie in the tract of distribution of some cutaneous nerve and its branches. Occasionally the tracts of two or more nerves are implicated; but, even in such a case, each one will be accompanied by its own eruption, which will be entirely distinct from the other. It is on this account that the eruption, when occurring upon the trunk, ceases abruptly at the median line, almost always. I say the latter advisedly, as will appear later on. It does occur sometimes, however, that the corresponding cutaneous nerves of the trunk on either side will be simultaneously affected, and then we have true "cingulum," or "girdle-rash," which superstitious in former years regarded as inevitably fatal. Old cronies to-day will assert that when shingles goes around the body the patient dies. There is no doubt whatever that the attack is more severe, but it is not a fact that it is fatal. The reason ascribed for the eruption abruptly ceasing at the median line is that the nerves do not cross it, and yet there seems to exist exceptions to the rule. An example of such a condition is shown in Figure 1. The patient, a woman, was affected by a zona extending over the left hip and lower part of the abdomen. In the dorsal region, at about the lumbo-sacral juncture, a patch of vesicles extended horizontally across the median line. This certainly goes to show that cutaneous nerves occasionally develop aberrant branches after complete fusion of the embryonic clefts has occurred. It is also of value as a warning to the physician not to reject a diagnosis of zona from the mere fact that a patch slightly overlaps the median line. Such cases are by no means as rare as text-books might lead us to suppose, and a little more attention to this point will reveal a greater number of these apparent exceptions.

As has been stated above, the vesicles in zona are filled with a serous, translucent fluid which, later on, becomes opaque and undergoes purulent transformation. It is not an infrequent occurrence for a number of vesicles which are in close proximity to coalesce. If the lesions are not subjected to friction, or to some similar external influence, crusts will form and develop in the course of eight or ten days and then drop off. As a sequel to these crusts there are very thin scars which are stained a rather light-brownish color and, in the course of time, become white, so that the former site of the lesions may be easily discovered years after they first appeared. Should the vesicles be bursted it is not unusual, but rather the rule, for ulcers to form. These ulcers are peculiar in their course as well as in their nature. They are rather deep and the destruction of tissue is well marked. Not only this, but they have a tendency to be chronic and do not heal readily, even under the best of treatment. Rather thin and unhealthy



FIG. 1. Zona Crossing Median Line.

crusts form which are not closely adherent, but fall off at the slightest provocation. The secretion is purulent and somewhat sanious, and there is a considerable amount of pain present. The cases which are affected in this manner naturally last longer than those which are properly treated. The disease, as a rule, will continue for two or three weeks if untreated, and the ordinary methods employed for combating the disease curtail this but little. On the other hand, an abortive treatment which is efficient and which will be outlined further on will succeed in reducing the length of an attack from four to six days. At least such has been my experience in a number of cases, and I have called attention to it in a former paper published by me.* The method was found to be efficient in both children and adults.

When zona attacks young children the process differs somewhat in its evolution from the same disease occurring in adults. As a rule, it is not preceded by neuralgia, and the younger the child the less complaint there

* *St. Louis Medical and Surgical Journal*, August, 1896.

is on that score. This cannot be explained in any other way but that which has been adopted to account for the fact that infants suffer less pain and its after-effects are shorter, in an operation, than in the case of adults. The only rational explanation which has been given for this fact is that



FIG. 2. Zona of Back.

the nerves and nerve centers are not as well developed; in other words, they are still in the stage of development, and the higher nerve and brain centers are not in that receptive state which they assume later on in life. The functions of the being are purely vegetative, and all evidences of emotion are referable to interference with those functions, with the possible

exception of pain due to trauma, and this is of comparatively short duration. On the other hand, when zona occurs in young children there is apt to be quite a marked elevation of temperature. This is known as zosterian fever, and is directly due to the disease, which is, no doubt, an irritation of the nerve centers. It occasionally becomes alarming, and should be combated with antipyretics such as are not heart-depressant, for the heart is also apt to suffer from some transitory functional disturbance more alarming from an apparent standpoint than from a real one.

The localities attacked by the eruption may be said to embrace the entire integument. The lumbar region and the thorax are most frequently attacked. Thus, we have *zona pectoralis*, *zona dorsalis*, as shown in Figure 2, in which it can be plainly seen that two spinal nerves are impli-



FIG. 3. *Zona of Leg.*

cated. *Zoster lumbalis* is also a favorite site, and the case shown in Figure 1 was of this variety. The sides of the chest, about the eighth or ninth intercostal nerves, is the most frequently implicated region. I have had occasion to note the eruption over those portions corresponding to the musculo-spiral nerve, the distribution not only mapping out very distinctly the nerve, but its branches. *Zona brachialis* is not seen very often. When it does occur, it is very apt to implicate the entire arm from the axilla to the flexure of the wrist. *Zona cruralis* is more often seen, and it is not unusual to see it distributed from the points of origin of the crural plexus down over the thigh and leg, the lesions being very disseminate.

An example of this form is shown in Figure 3, the lesions below the knee being younger in point of appearance than those above. The most severe form of zona is, beyond all doubt, that which is localized over the area supplied by the first branch of the fifth cranial nerve. This constitutes zoster ophthalmicus, and it is not only the most severe in its subjective symptoms, but is also very apt to be of a severely destructive character. A vesicle developing on the cornea is very prone to lead to perforation, with all which such a condition implies. It is for this reason that most energetic measures should be employed, as the loss of sight in one eye is always a contingency which should be guarded against. It is also for this reason that zona should be recognized quite early, as treatment may be inaugurated earlier and a disaster to eyesight much more easily averted.

The pathology of this disease has been very thoroughly worked up, although there are yet some lacunæ to be filled. The exact demonstration of the anatomico-pathological origin of zona must be credited to Bærensprung, who discovered changes in the cutaneous nerves and spinal ganglia.* But, as Leloir very justly observes,† cases occur in which neither the nerve trunks nor the ganglia are affected, and in which, manifestly, the cutaneous terminal filaments suffer. At all events, all writers and investigators are of the common opinion that there are organic changes in the nerves or spinal ganglia, or both, and that the cutaneous eruption is simply a reflex symptom of this condition, just as all herpetic eruptions are indications of some deeper neurotic diseased state, whose exact nature must be determined and eliminated before any decided and permanent relief can be hoped for.

An interesting question in connection with zona is the consideration of what causes it. Upon this problem there exist, in general, two opinions, and treatment accordingly varies. One opinion, which is supported by very respectable authority, is that the cause is purely parasitic. Micro-organisms cause the trouble and the disease originates from without; or, in other words, is purely extrinsic. The theory which I am inclined to favor is that of the intrinsic origin. Experimental inoculations have failed, in my hands, to reproduce the eruption. On the other hand, I have been able to trace the inception of the trouble to a cold, exposure to air, being chilled, getting the clothing wet and thus reacting on the cutaneous surface, a chill being marked; mental emotions, such as anger, a fright, etc. In all, some nervous phenomenon could be made out and the relations of cause and effect appeared very plain. On the other hand, I have seen a zona-form eruption appear as a result of the intoxication produced by Fowler's solution. No neuralgic pains were apparent, but in all other respects it was a typical zona in each case. In connection with this part of the subject it may not be uninteresting to mention the fact that it has been, and still is to some extent, a popular belief, supported by medical authority, that one attack of the disease confers immunity against subsequent attacks. Very good evidence has gone to show that this is a fallacy, and quite a large number of individuals have been reported (orally) as having suffered successive attacks, one as often as once a month, showing that this is far from being an unusual occurrence.

* *Annalen der Charité*. Volume XII. Berlin, 1868.

† *Recherches Cliniques et Anatomico-Pathologiques sur les Affections Cutanées d'origine Nerveuse*. Paris 1882, p. 153, et seq.

The treatment of zona should be both general and local. The prodromic symptoms should be treated by some nerve sedative, but cases rarely apply at this early stage for treatment, a belladonna or mustard plaster or some similar treatment being employed by the patient, who considers it an unimportant neuralgia. It is when the disease is developed, when the cutaneous lesions appear, that the pains are most marked. Here it is that energetic employment of remedies must be carried out. Phosphide of zinc, in one-third grain doses, has been recommended, the dose indicated being given four times daily, but it does not seem to be adequate to the cases. A good pill is the Asiatic, made as follows:

℞ Acidi arseniosi gr. i
 Pulv. piperis nigris ʒ i
 Ext. gentianæ q. s.
 M. Ft. pil. No. 30. Sig.—One pill after each meal.

This is superior to Fowler's solution, as it produces no untoward symptoms. If there be much pain at night, opium acts as the best sedative.

Locally, the treatment may be summed up in two words—protection and anodynes. A powder composed as follows is good:

℞ Pulv. camphoræ ʒ ss
 Talc. veneti
 Cretæ preparat.aa ʒ j M.

But pure campho-phénique powder is much better. Whichever is used, it should be freely dusted on the affected part, and the whole covered with cotton batting. Should the local pain be very intense, it will be found advantageous to apply a four per cent. solution of cocaine muriate before the use of the dressing. Various anodyne solutions have been recommended, such as aqueous solutions of carbolic acid, bichloride of mercury and tincture of opium. The calamine and zinc lotion has been applied, but powders will be found to act much more satisfactorily. But whatever application is determined on, it should never be forgotten that the use of a cotton dressing is of the utmost importance. It protects the blebs and vesicles from being broken, and thus prevents the formation of chronic, ill-conditioned ulcers which will otherwise result and leave marked scars to demonstrate their former presence.

The prognosis of zona should always be a good one. The majority of authors give the average duration of the disease as two or three weeks. By using the treatment outlined above (arsenic pill and campho-phénique powder), this will be shortened to from four to six days, a circumstance which will be highly appreciated by patients.

Dr. John Guiteras.—Dr. John Guiteras has returned from the yellow fever infected district of the South to his home in Philadelphia.

Chicago Brains.—A society has been organized in the University of Chicago, the members of which will bequeath their brains to the society, as well as write out truthful, conscientious, and so far as possible unbiased, history of their mental processes from the beginning to the end of their lives.

TUBERCULOSIS SUCCESSFULLY TREATED BY HAGEE'S CORDIAL OF COD-LIVER OIL.—A REPORT.

By WM. CLARENCE BOTELER, M. D., of Kansas City, Missouri.



PARADOXICAL, as it may sound to those remembering only the earlier taste of cod-liver oil, the present generation witnesses the conversion of what was, until a comparatively recent date, the most nauseous of our remedies into almost a beverage for the invalid—a delightful cordial, in fact. That the taste of various preparations of this valuable remedy was an impediment to therapeutics from its disgusting features, few will deny: but this was not all; the preparations in earlier use were loaded with extraneous organic and inorganic matters and unassimilable fat globules in excess of

human power of digestion, hence the stomach soon became impatient of such duties, rejecting them and leaving the sufferer often badly treated.

We are due much gratitude to the progress of science in every field, but if we will consider the acknowledged value of the active principles of *ol. morrhuæ* in tuberculosis, and again pause to reflect upon the grave nature of the disease, the introduction of the electric light could not be of more value to invention than the accomplishment of a combination of the active principles of cod-liver oil in a delightful cordial is to the consumptive.

Older physicians, as we know, tried to overcome both the repulsive taste and the indigestible nature of the remedy by the co-administration of whiskies: correctly inferring that in persons markedly subnormal, as are consumptives, the vascularity of the digestive apparatus must be gently excited to insure a free secretion of digestive fluids, the emulsification and assimilation of the oil.

This quaint practice with "cod-liver oil and whiskey" foreshadowed, both chemically and therapeutically, the present splendid achievement known as Hagee's cordial of cod-liver oil. It compares with its ancestor as does the arc light with the tallow dip of revolutionary times.

No less does the cordial of cod-liver oil surpass former preparations in therapeutic value; it is soothing, stimulating and grateful, promoting appetite and assimilation in any of the varied phases of phthisis pulmonalis at any age from the cradle to the grave. The following report, though lacking the completeness of repeated microscopic examinations of the sputum, fully sustains the excellence of a remedy that words can but faintly portray: Patient, Mr. M. W., an adult, male, aged 37, occupation laborer and mortar mixer; consulted me September 21, 1896, with the following

history: His mother had died when he was a child, and his father later, "of lung trouble;" until three years ago he had enjoyed excellent health, worked regularly, and had no pulmonary symptoms; in November, 1893, he caught cold from being overheated at work and a fall in temperature; the "cold" resisted all treatment; cough persisted; night-sweats ensued a sense of constriction seemed to have settled in the upper part of his left lung; his cough was worse at night; he possessed an aversion to fatty articles of food; his appetite was poor; sometimes his expectoration was streaked with blood; he steadily lost flesh, until at the time of consulting me he was reduced from 163 to 121 pounds. A complete physical examination, coupled with this hereditary and clinical history, pointed to tuberculosis of the lung, the upper lobe taking little part in aeration. The bacillus was easily detected in mucous scraped from the glottis.

In as much as there had been no very pronounced hemorrhage and fearing its occurrence, Mr. W. was at once placed upon improved regimen and diet; thirty drops of fl. ext. ergot in two tablespoonfuls cordial cod-liver oil, three times daily. The ergot was continued about thirty days till the sputum cleared, then the cordial was persisted in until the present time. December 24, 1896, the lung was clear on percussion, excepting a small area at the apex; no cough; no night-sweats; chest expansion increased from three-fourths to one and one-fifth inches; expectoration clear; appetite good; urine high colored; bowels inclined to be loose; patient weighing 161 pounds; says he feels entirely well and expects to go to work at his trade as a mixer of mortar with the opening of spring. This case can be called well, although treated as an out-patient, if no backsets occur within a short time: and whilst I regret my inability to give periodic results of microscopic examinations of the sputum, the very remarkably prompt arrest of the retrograde processes by this remedy, and the adverse hereditary and personal history, justify the conclusion that in cord. ol. morrhue comp. (Hagee), we have an agent of unusual value and of ready adaptability to the flagging needs of the system in especially the first and second stages of the disease.

Clinic by Dr. Eastman.—A special clinic in honor of the Southern Surgical Association was held at the City Hospital, Seventeenth and Pine streets, Tuesday, November 9th, at 8 o'clock P. M., under the auspices of the St. Louis Academy of Medical and Surgical Sciences. Prof. Joseph Eastman, M. D., LL. D., of Indianapolis, Ind., made an abdominal section for pyosalpinx.

Officers of the Academy.—At a recent session of the St. Louis Academy of Medical and Surgical Sciences the following officers were elected for the ensuing term: Dr. A. H. Ohmann-Dumesnil, President; Dr. G. C. Eggers, Senior Vice-President; Dr. J. B. Ross, Junior Vice President; Dr. Emory Lanphear, Secretary; Dr. Geo. F. Hulbert, Treasurer; Dr. Geo. H. Thompson, Curator; Dr. Phil. Scholz, Orator; Dr. James Moores Ball, Librarian.

FORMULÆ.

Blackheads.—Blackheads are not, as is generally thought, dust or dirt accumulated in the pores, but consist of fatty secretions of the skin and a coloring matter. The following mixture may be recommended for their removal:

℞ Kaolin parts iv
Glycerine parts iij
Acid acetic parts ij
Ol. odorat., ad lib.

M. Sig.—Apply this mixture to the parts at night, and, if possible, also several times during the day. The blackheads will disappear when washed with this mixture and rubbed freely with a towel moistened with it, or can easily be removed after a few days.—*Fulch's, Practical Druggist; Cincinnati Lancet-Clinic.*

Mixture for Whooping-Cough.—

Guaita (*Semaine médicale, Progres Medical*) gives the following formula:

℞ Phenocoll hydrochloride,
Antipyrine aa gr. 7½
Potassium bromide gr. 6
Syr. bitter orange peel
Orange-flower aq aa gr. 380

M. A child eight years old may take the whole amount in four doses, in the course of twenty-four hours.—*Ex.*

Hay Fever.—For inhalation Dr. William Murrell recommends in the *Medical Brief*:

℞ Menthol gr. viij
Chloroformi m v
Benzol m xx
Ol. of cassia m iij
Light carb. of magnes gr. xx
Aq., to an ounce.

M. Sig.—A teaspoonful is poured into a pint of hot water at a temperature of 140° F., and the vapor is slowly inhaled for ten minutes.—*Med. Bulletin:*

Mouth Wash for Mucous Patches.

℞ Acid. pyrolog ʒ j
Aq ʒ viij

M. Sig.—Wash the mouth every four hours.—*Horwitz, Med. Summary.*

Antiseptic Lubricants for the Catheter.—Guiard (*Annales des maladies des organes génito urinaires*), recommends the following formulæ:

℞ Carbolic acid part j
Sterilized ol. sweet almonds parts xxv

℞ Porphyzied boric acid part j
Sterilized white vaseline parts vj

℞ Sterilized powd. soap
Sterilized glycerin
Sterilized aq aa parts xj
Resorcin, beta-naphthol or
absolute phenol part j

M. This is Guyon's soluble ointment. It has the advantage of being readily removed by washing.—*Ex.*

Bromoform Syrup.—The following formula has been warmly recommended:

℞ Bromoform gtt. 40
Green tinct. acopite gtt. 50
Syr. codeine fl ʒ iss
Syr. Tolu
Syr. red poppy aa fl ʒ ivss
Alcohol fl ʒ iiss

The dose can be graduated according to the age of the patient. This mixture has been found useful in whooping-cough, bronchial catarrh, and the pneumonia following measles.—*Amer. Med. Surg. Bulletin.*

Favus.—Tsitrine calls attention to the following formula introduced by Pirogoff for the treatment of favus:

℞ Sublimed sulph ʒ ss
Potass. carbon ʒ j
Dest. tar
Tinct. of iodine aa ʒ iss
Lard ʒ iij

M.—*Practitioner.*

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EDITORIAL DEPARTMENT.

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NO. 11.

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THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

This society met in Saint Louis, November 9, 10 and 11, 1897. The attendance was large, the papers of great value, and the discussions interesting. Some of the most distinguished surgeons of the United States are members. Their work is given a permanent form by the publication of elegant volumes of transactions. These are highly prized and are found in every large medical library. One will find in them records of much original work in surgery and gynecology. Such is the reputation of this society that many applications are on file for membership, which is limited to one hundred and fifty.

While the meeting was beyond criticism, as far as our guests are concerned, not so with the local profession. It is unfortunate that the Committee of Arrangements was so bigoted, narrow-minded and contracted that many of the ablest men in the Saint Louis profession were either deliberately snubbed or were invited to attend the banquet only at the eleventh hour and fiftieth minute—thus showing that their money was wanted more than their presence. Such conduct well becomes men who are teaching in the two medical colleges (Saint Louis Medical College and Missouri Medical

College) of this city which were condemned recently by the Saint Louis Medical Society for the abuse of medical charity.

The most important feature of the meeting was the reception given by Dr. A. C. Bernays (who is not a member of the society) to Dr. Howard A. Kelly, the distinguished Professor of Johns Hopkins Medical School. Over three hundred and fifty physicians turned out to honor Dr. Kelly—a larger number of physicians than ever were in any one doctor's house in this city, it is said. The broadmindedness of Professor Bernays was in marked contrast to the bigotry of some other local surgeons.

Another feature of interest was the surgical clinic held in the Saint Louis City Hospital by Dr. Joseph Eastman, of Indianapolis, under the auspices of the Saint Louis Academy of Medical and Surgical Sciences. This was attended by about two hundred physicians. Dr. Eastman left a good impression with his audience. For this clinic the Academy is grateful to Dr. Otto Sutter, Superintendent of the City Hospital. All physicians were welcome at the clinic, for the Academy is a liberal body.

On the second day, by courtesy of Dr. Sutter, Dr. Kelly was enabled to demonstrate his method of catheterizing the ureters—a demonstration showing the marvelous skill of the gentleman.

A little incident occurred at Bernays' reception which was amusing to those who know the *status praesens* of medical matters in Saint Louis. Some months ago an alleged medical journal of this city, which claims to be a mirror of medical progress, printed an article charging Professor Kelly with theft. It stated that the Professor of Johns Hopkins had not originated the method of catheterizing the ureters, but had stolen it from a foreigner. The editor of the aforesaid sheet had invited himself to the reception and was apparently the "whole show." Dr. Bernays, in talking about his distinguished guest, spoke of the charge, said he had fully investigated the matter, and pronounced it a despicable lie. The journalist soon took his departure.

There was a noticeable absence of the local profession. The afternoon of the second day, when the Association was at its height, only fourteen members of the Saint Louis profession were present. The cause of this is easily found. It was the personnel of the Committee of Arrangements. Four of its members are members of the St. Louis and Missouri Medical

Colleges, two institutions which were recently condemned by the Saint Louis Academy of Medical and Surgical Sciences, and later by the Saint Louis Medical Society, for the abuse of medical charity. At least

two of the members of the committee are notorious newspaper advertisers. No wonder that the cream of the Saint Louis profession remained at home! No physician with any self-respect would care to remain in such company for any length of time. Only a few sycophants were present to represent the medical men of this great City. While we wish success to the Southern Surgical and Gynecological Association, we hope that the next time the society meets in Saint Louis a representative Committee of Arrangements will be selected.

TIME FOR ANOTHER INVESTIGATION.

Several months have elapsed since the Saint Louis Medical Society investigated the fifty-cent hospitals and cheap doctors of this city. It is now time for another investigation. We are informed that some of the offending members of the medical society who promised to mend their ways have gone back to the fifty-cent plan. If they would only resign from the society all would be well, but they are trying to carry water on both shoulders.

Another matter which should be looked into is this: some time ago this JOURNAL printed a list of men who were consultants to a Baptist institution in this city which had drummers on the road stealing the patients of country doctors. The institution denied the allegation long after every one knew it to be true, but finally issued a statement that the drummers had been withdrawn. It is now rumored that the old plan has been revived.

We are informed that another Baptist institution of this city is sending out quackish literature to laymen.

SHOULD NOT BE RECOGNIZED.

The Missouri State Medical Association should see to it that no more delegates holding credentials from the St. Louis Medical Society be accepted. Of all the aggregations of ethical quacks, the St. Louis Medical Society easily ranks first. When men who have heretofore been honored by this and other medical societies deliberately contract with a newspaper to print their obituary notices while they are yet alive, it is time for a protest; when well-known surgeons are found to have their valuable prescriptions for a common and plebian cold printed in the daily press, it is time for a protest. When we consider how studiously some of our dear brethren ponder over the question, "How can I get a free ad. and not be caught?" it is time for a protest. When religion is made a thing to be traded upon by doctors, it is time for a protest. When the ethical quacks establish a free clinic in a region where pauperism is unknown, it is time for a protest. When the sanitariums and hospitals, particularly of the Baptist persuasion, employ reverend drummers to steal the patients of country doctors, it is time for a protest. When the goody-goody ethical quacks go to the medical society and tell the young men how to conduct themselves according to the "code," it is time for a protest. When a few doctors who are members of a chartered institution can openly violate all principles of right, as well as the "code," and shield themselves under the articles of incorporation, it is time for a protest. When illiterate doctors are elevated to medical professorships, it is time for a protest. When the ethical charlatans pick out a poor devil of an advertising doctor and make him a scapegoat for all of the sins of all the ethical quacks, it is time for a protest. When good and honorable men are so disgusted with the St. Louis Medical Society that they refuse to affiliate with it, it is time for a protest. When members of the St. Louis Medical Society secretly aid and abet "fifty-cent hospitals," it is time for a protest.

If the medical men of the great city of St. Louis can be represented in the Missouri State Medical Association only by and through the St. Louis Medical Society, it were far better to go without representation. But such a calamity can be avoided. For the St. Louis Academy of Medical and Surgical Sciences has had its credentials accepted and will be heard from at the coming meeting of the State Association.

AIMS OF THE MISSOURI MEDICAL LEAGUE.

The Missouri Medical League has just issued a circular letter giving information as to its intents and purposes. The League says:

With all the evils rampant, connected with clinics generally, newspaper advertising, fifty-cent hospitals, ticket associations, religious annexes *et id omne genus*, it is time to consider, whether the Medical Code is a dead letter or worthy of the support of the noblest of professions. If the Medical Code is an antique and a back number, the sooner it is known and recognized to be such, the better. It is just and reasonable that the same rules of conduct which regulate and apply to individuals should govern the actions of bodies of men. The earlier this proposition is accepted, the quicker will a healthier and more wholesome polity be inaugurated in the medical profession.

In order to emphasize the necessity of a collective action on the part of the profession, it has been deemed desirable to form a Society or League, the chief objects of which, among others, is to look after the varied medical interests, appertaining not only to the physician, but to the citizen. To accomplish telling results it is imperative that the co-operation of every honest, honorable and sincere member of the profession be obtained. Some of the aims of the Missouri Medical League are as follows:

1. To unite fraternally Doctors of Medicine in good standing for mutual protection.
2. To secure by united action such laws as shall benefit and protect the medical profession.
3. To influence doctors of medicine to be good citizens in the highest sense of the term, and to urge upon them the necessity of taking an active part in matters appertaining to State and local government, and of voting at every election.
4. To collect evidence of any hospital and dispensary abuses.
5. To regulate the practice of Medicine.

This circular letter has been sent out principally for two reasons:

1. To stimulate the profession to a proper recognition of the facts as they exist, and
2. To secure the co-operation of the doctors throughout the State in any action directed to the betterment of the profession. They, who are in sympathy and accord with the purposes of the League, will kindly signify it by communicating with the Executive Committee.

CONCERNING OURSELVES.

We are late this time. The absence of the business manager from his desk, and an unusual amount of work thrown on the editor's shoulders, has resulted in the *JOURNAL* going to press very late. We trust it will not occur again and ask the indulgence of our friends.

NEW SUBSCRIBERS.

A large list of new subscribers is crowded out of this issue. It will appear in next month's *JOURNAL*. One of our solicitors is in Iowa doing splendid work. Many subscriptions are being received by mail. We are growing. We hope to keep on growing in spite of politics, high tariff and low cotton.

THE MEDICAL LEAGUE UPHELD.

Resolutions approving the aims and objects of the Missouri Medical League were recently introduced in the St. Louis Academy of Medical and Surgical Sciences and the St. Louis Medical Society by Dr. Ball. These resolutions were passed without a negative vote. The League can be sure that it possesses the support of every member of the Academy, and of the ethical members of the St. Louis Medical Society. Unfortunately, the latter Society has in its ranks some of the worst disorganizers in the Missouri profession.

OUR NEW ADVERTISERS.

During 1898 we will publish the best medical journal in America for the money. We will be able to do this for two reasons: the great growth of our subscription list, and the increase in our advertising pages. The *TRI-STATE MEDICAL JOURNAL* is now four years old, and enters its fifth year with bright prospects. Some idea of the value of this magazine may be gained from the following list of new advertisers who have recently favored us with contracts for the first time:

Lehn & Fink, New York;
Stallman & Fulton, New York;
Kress & Owen, New York;
McKesson & Robbins, New York;
M. J. Breitenbach Co., New York;
C. Bischoff & Co., New York;
The Pheno-Bromate Chemical Co., New York;
Merz Capsule Co., Detroit;
Dr. Becker Compound Digest Co., Chicago;
California Fig Syrup Co., San Francisco.
Howard Chemical Co., St. Louis;
Mellier Drug Co., St. Louis.



Victorian Beds.—The Victoria Diamond Jubilee Association, of Chicago, has raised \$7,000 to be distributed among Chicago hospitals. St. Luke's Hospital will receive \$3,000; the Presbyterian Hospital, \$3,000; the Mary Thompson Hospital, \$500; and the Maternity Hospital, \$500. The association asks that the hospitals name the bed, room or ward thus established in honor of Queen Victoria.

Oxy-Tuberculine.—The latest cure for consumption, called oxy-tuberculine, has been devised by Dr. Joseph O. Hirschfelder, of San Francisco, and the lymph is prepared by injecting the tuberculine into veal. The treatment seems to be indorsed by Cooper Medical College, after careful examination of the patients treated. It is said to solve the problem which Koch failed in doing.

Wabash Surgeon.—Dr. Richard Grinstead now has charge of the surgical work of the Wabash Railway in St. Louis, *vice* Dr. W. A. McCandless.

Ethical Advertisers.—Speaking of doctors who belong to medical societies and yet resort to newspaper advertising, Lanphear's *Journal* asks: "Is such conduct to go on and on to the eternal disgrace of St. Louis? For decency's sake, let these men be made to either quit their unethical conduct or forfeit their membership in the medical societies."

Died.—Mr. Isaac Bell, who recently died at an advanced age, was the originator of the present system of managing the charities of New York, in place of that of the old board of governors.

Becker's Compound Digestive.—The advertisement of this preparation will be noticed on another page. Samples will be furnished by applying to the Dr. Becker Compound Digest Co., 107 Dearborn street, Chicago. Mention this JOURNAL.

Death of Dr. F. D. Mooney.—His many friends will be pained to learn that Fletcher D. Mooney, M. D., of 3035 Washington avenue, St. Louis, died on November 9th. For several years he had been ill, but able to attend to practice. Dr. Mooney was forty-one years old, and came here from Springfield, Mo. He graduated in 1880 from the Missouri Medical College. He was physician to the Insane Asylum for two years, and then resigned to begin private practice. He was subsequently connected with the Missouri Medical College in different capacities. He was Secretary of the St. Louis Medical Society for a number of years, as well as its President. At the time of his death he was a teacher in the Beaumont Medical College, occupying the chair of Abdominal Surgery. Dr. Mooney was always prominently identified with medicine in St. Louis, and was considered one of the most skillful surgeons of the city.

ARKANSAS ITEMS.

Appointed.—Dr. J. M. Keller, of Hot Springs, has been appointed Surgeon-General of the Arkansas Militia, with the rank of colonel.

Dr. J. T. Jelks.—Dr. Jelks, of Hot Springs, attended the recent meeting of the Southern Surgical and Gynecological Society at St. Louis.

Made a Professor.—Dr. D. M. Appel, of the United States Army Medical Corps, was elected to the chair of bacteriology in the Medical Department, Arkansas Industrial University, at the last annual meeting.

Dr. Davis.—Dr. Davis, of the Eureka Springs Sanitarium, was recently in Chicago on business.

Removed.—Dr. Buchanan Hatchett, of Fort Smith, who located in St. Louis some months ago, found the climate injurious and has gone back to Arkansas. The doctor is a rheumatic.

Located.—Dr. Louise N. Miller, formerly of Eureka Springs, has located in St. Louis.

Visited.—Dr. A. I. Moore, of Fayetteville, recently was in St. Louis for a few days recently.

In St. Louis.—Dr. William Clay Cardwell, of Carrollton, is spending the winter in post-graduate study in St. Louis.

Tri-County Medical Society of Arkansas.—This society met in annual session at Berryville, November 5 and 6, 1897, with a good attendance. The society is composed of regular physicians living in the counties of Newton, Boone and Carroll. Dr. J. B. Bolton, the President, presided. Papers were read as follows: "Electro-Therapeutics," by Dr. W. B. Sprague, of Eureka Springs; "Typhoid Fever," by Dr. L. Kirby, of Harrison; "Tangents in the Practice of Medicine," by Dr. H. L. Routh, of ; "Nasal Headaches—Cause and Treatment," by Dr. E. L. Evans, of Harrison; "Report of Cases From Practice," by Dr. J. B. Bolton, of Eureka Springs; "Report of Eye Cases," by Dr. James Moores Ball, of St. Louis.

A pleasant feature was the banquet given by Drs. W. P. George and I. M. Poynor, of Berryville. The next meeting will be held in Harrison, at a time to be decided by the officers. New officers were elected as follows: President, Dr. G. V. Poynor, of Green Forest; Vice-President (Carroll Co.), Dr. W. B. Sprague, of Eureka Springs; Vice-President (Boone Co.), Dr. E. L. Evans, of Harison; Vice-President (Newton Co.), Dr. J. C. Blackwood; Secretary, Dr. I. N. Poynor, of Berryville; Treasurer, Dr. L. Kirby, of Harrison. The TRI-STATE MEDICAL JOURNAL AND PRACTITIONER was made the official organ of the society.

Removed.—Dr. W. L. Yandell has removed from Valley Springs to Jasper.

ABSTRACTS.

IRREGULAR MENSTRUATION IN YOUNG WOMEN DUE
TO ANEMIC CONDITIONS.

By H. EDWIN LEWIS, M. D., Burlington, Vt.,
Resident Physician Fanny Allen Hospital.

The young physician just starting into practice cannot help but be impressed with the frequent occurrence of menstrual disorders in young girls during the period just succeeding the age of puberty. The metamorphosis of a girl into a woman, consisting as it does of structural and functional changes throughout her body, in many instances leaves behind pronounced alterations in the quality or even quantity of the blood current. How common it is to have a mother bring her daughter to the physician and say: "Doctor, I would like to have you do something for my daughter. For nearly a year she has been losing interest in everything and seems to be completely worn out. She has no appetite and absolutely no ambition for work, study or play. She does not lose flesh or grow thin at all, but her color is so poor and she seems so weak that I fear she is going into consumption."

Inquiry on the part of the doctor elicits the further information that the young lady in question is sixteen years old or thereabouts, and that she is a school girl. A year or two ago she first menstruated and since that time has been unwell only twice, or at irregular intervals varying anywhere from three to nine months. Her bowels are either constipated or the reverse, and she may complain of headaches, vertigo, palpitation of the heart, insomnia, indigestion, etc., etc. The pale face with its sallow greenish tinge, the bleached tongue, the colorless conjunctivæ and finger-nails, tell well the tale of impoverished blood. Combine the history with the objective symptoms and the diagnosis is clear of chlorosis or green sickness. The absence of cough or pulmonary symptoms excludes the dreaded "consumption," but we have instead a condition of the blood in which the essential constituents are diminished and the whole quality of the life-giving current so depreciated that the various organs of the body are unable to perform their normal functions. The uterus is small and ill developed and the supply of rich blood it so urgently requires in its developmental state is not to be had. Is it any wonder, then, that the chlorotic girl does not menstruate regularly? It is a great wonder that she ever menstruates at all. Correct the anemic or impoverished condition of her blood and the physiological function of her uterus will be resumed as naturally as that of any other organ.

How this chlorotic condition can best be corrected is the next question and one which because of its frequency concerns every practicing physician. Countless remedies have been presented to the profession, but far and foremost above them all is iron, notwithstanding certain high authority to the contrary. Arsenic is certainly valuable, but it ranks far below

iron or even manganese in the therapeutics of anemia. In order to be most efficacious, however, the iron should be in its most readily assimilable form, and until recently the carbonate and albuminate have been supposed to present this requisite in the highest degree. But since manganese has grown in favor as an adjuvant to iron, a new preparation has been submitted to the medical profession, *and in every way it has proven itself an ideal one.* I refer to Dr. Gude's preparation of the peptonate of iron and manganese, known as pepto-mangan. This admirable combination of iron and manganese is readily taken into the human economy and appropriated to its needs, without deranging the weakest alimentary tract, or hindering in any way the normal processes of digestion, assimilation and excretion. It should be given in water or milk in teaspoonful doses after meals, and its administration is invariably followed by the results desired.

But in order that the medical treatment of chlorosis may be most valuable and efficient, it should be augmented by auxiliary treatment consisting of careful attention to diet and exercise. It goes without saying that the food of an anemic girl should be most nutritious and particularly abundant in albumen, while the exercise should aim to provide greater quantities of oxygen in the form of pure air, without lowering the vitality. Walking, skating, tennis, or bicycling in moderation are all able to supply the demand for exercise.

Treatment laid down on the above lines, followed out in every instance with good habits of hygiene and a careful observance of nature's demands, will regulate the various functions of the body, and the menstrual function will prove no exception to the rule.

The following cases will substantiate the above:

CASE I.—Miss C. S. K., seventeen years old. Decidedly anemic and much troubled with constipation. First menstruated at fourteen, since which time she has never been regular, flowing profusely sometimes twice a month, and other times going three or four months without menstruating at all. Has frequent fainting spells and a decided anemic heart murmur. At time of coming under observation had not menstruated for two months and ten days.

Treatment consisted of a regulated diet, tablets of aloin, strychnine, belladonna and cascara sagrada, one each evening until bowels were regular, and teaspoonful doses of pepto-mangan (Gude) after meals. Gradually the fainting spells and heart symptoms disappeared and on the fifteenth day after commencing treatment she began to menstruate, the flow being natural in quantity and continuing four days. Treatment was continued and twenty-nine days later she menstruated again, continuing this time five days. Soon after this the pepto-mangan was stopped. From now on, up to the present time, a period covering three months, her menses have appeared regularly every twenty-eight days.

Her whole appearance is changed and in every respect she appears well and strong. Period of administration of pepto-mangan fifty-five days.

CASE II.—Miss K. M., aged twenty. Menstruated first at age of fifteen and was fairly regular for three years, but since an attack of typhoid fever two years ago has never known when she was going to be unwell. Patient was not thin, but face was pale and yellowish, hands and feet were

cold "all the time," and her whole condition was one of "blood poverty." Complained of frequent attacks of diarrhœa following constipation.

Treatment consisted of plenty of out-door exercise, good food with abundance of milk, and pepto-mangan (Gude) in teaspoonful doses after meals.

Her restoration to health has been rapid and satisfactory. She has menstruated three times since beginning treatment, the longest interval being thirty-one days. Says she is all right and her appearance certainly sustains her words.

In this case the administration of pepto-mangan covered a period of thirty-six days.

CASE III.—Miss D. L. School girl. Aged fourteen. For two years she has been troubled with headaches, dizziness and short breath, fainting away at the slightest provocation. Had no appetite and, as her mother expressed it, "for the last six months had been going down hill pretty fast." Had been treated by a physician for heart disease, but received no benefit. Menstruated first seven and a half months ago, "but had not seen anything since."

Examination showed heart to be normal, although it was a trifle fast, and a slight murmur could be determined when the patient was in a recumbent position, evidently anemic in origin. Lungs proved to be all right.

Her general condition was anemic and she was put on pepto-mangan (Gude) a teaspoonful after meals, and sent into the country where she could be out doors most of the time and have plenty of eggs and milk. A letter from her mother says that she has changed so that she can hardly believe it is the same girl. Furthermore, her menses appeared twenty-one days after starting the pepto-mangan and returned again twenty-nine days after. The pepto-mangan was ordered stopped and since then I have not heard direct from the patient, although from her father I learn that she is "perfectly well" and coming home soon.

Period of administration of pepto-mangan, fifty-six days.

CASE IV.—Miss L., aged eighteen. Had never menstruated. Her general appearance was one of profound anemia. A careful examination eliminated any abnormality of genital apparatus. Organs normal in relation, but undersized. Prescribed pepto-mangan in teaspoonful doses after meals and gave general directions as to diet, etc. Began to menstruate thirty-two days after beginning treatment, the flow continuing one week. Twenty-nine days later she menstruated again. At the present writing she is still under treatment and is due to menstruate in seventeen days. Her whole condition is very much improved.—*Vermont Medical Monthly*, August, 1897.

Iron as a Therapeutic Agent.—One of the standard arguments of the homœopathic therapist in favor of infinitesimal doses, is that the administration of iron in large doses is wholly absurd, because more iron is often given in one dose than is contained in the whole system, and of it only the minutest portion is utilized by the bodily functions.

Too often iron is administered in such a way as to occasion this criticism, and of all its pharmaceutical preparations no one is accepted as the

best. During the last few years numerous substitutes for iron and special formulæ have been presented to the profession in an endeavor to furnish a more scientific method of administering this valuable drug.

The inorganic salts of iron, after administration to the lower animals, as in the experiments of Hamburger, may be recovered in almost identical quantity from the fæces, and absorption in any considerable degree is therefore impossible; yet, when, as has been estimated, the total amount of iron in the system is but forty-five grains, even such a slight loss may indicate that the blood has been supplied.

It has been the aim of pharmacology to obtain a preparation of iron identical with the form in which it exists in the body, an albuminate; and to Bunge must be ascribed the honor of first differentiating it in his hæmatogen.

Schmiedeberg later succeeded in separating from hogs' livers a compound in which the iron and albumen were combined in the same manner as in the body, which he called ferratin. To obtain a sufficient supply from this source was palpably impossible, and a synthetic compound was prepared by exposing a mixture of white of egg and iron to the action of slight heat in an alkaline medium; and so prepared, it contains from seven to eight per cent. of iron. It is absorbed in considerable quantities from the intestines, and does not appear in the excreta as do the inorganic salts and most of the so-called albuminates, and seems to offer a means of supplying the organism with what, under ordinary circumstances, is gained from the food, and when anæmia exists, the most rational method of restoring the essential element to the blood-cell.

The essential difference between ferratin and the ordinarily prescribed salts of iron is that to be assimilated they must all be changed to a compound similar to the former, if not identical with it, and this much work is saved to the digestive organs.

According to M. Cloetta, the organic combination of iron with albuminoid matter is necessary in order to insure its absorption. For instance, two dogs were experimented upon as follows: Their food consisted of a soup made of starch, sugar, glucose and distilled water. To the nourishment of the first dog, a solution of iron chloride representing sixty milligrammes of iron was added; to that of the second dog, a solution of ferratin representing forty milligrammes of iron. The villosities of the dog to which ferratin had been given presented the characteristic action of the iron absorbed. The iron contained in the intestine of the other dog was not absorbed and formed masses at the base of the villosities. The organic iron combined with albuminoids is evidently absorbed in the intestine, penetrates the chyle, and enters the circulation by the mesenteric veins.

Experiments made by Cloetta with new-born dogs demonstrated that the presence of iron salts in the food was not immaterial to the formation of hemoglobin; that there was no absorption of iron salts, and that the liver seemed to regulate absorption in the same way as it did glycogenesis.

Of the therapeutic value of ferratin, many careful clinicians bear testimony. The elaborate experiments of foreign observers do not, however, carry as much weight as do the reports of better known American physicians. Thompson, in the *Medical Review*, adduces clinical evidence of its value in the anæmia following parturition, which may be due to influences

which were present before the confinement, but were rendered inoperative on account of the great natural resistance presented by the organism against the invasion and extension of microbic infection. It is frequently the case that a local tubercular growth is in the lung, or that there may be a malarial infection, both of which may be held in abeyance as long as the cellular elements of the organism are normal; but when the vitality is temporarily depressed, and the receptivity of the body for infections increased, an opportunity is afforded for a serious and, perhaps, fatal extension of the hitherto latent affection.

Additional testimony is given by Flutterer, Einhorn and Chittenden, in *The Chicago Medical Recorder*, *The New York Medical Journal* and *The Dietetic and Hygienic Gazette*.

Its position in therapeutics seems to be well established.—*Atlantic Medical Weekly*.

Hypnotics.—We recently quoted a brief summary on hypnotics from the 1897 "Year-Book of Treatment," calling attention to the usefulness of the agents introduced during recent years, attesting the safety and superiority of chloral and chloralamid, admitting the value of sulfonal and trional—if used with care to prevent dangerous symptoms, and referring to pello-tine—the only new introduction of last year.

Nearly five years ago we compiled a list of "New Hypnotics," quoting trade and chemical names and synonyms, and giving brief therapeutic estimates of each. The article was widely copied at that time. It included all the hypnotics known now, excepting only trional and pello-tine. A similar list, emanating from some German publication, is going the rounds of the pharmaceutical and medical press now. It is a demonstration of the fact—only two new hypnotics having been introduced during the past five years—that the fear expressed occasionally in some quarters, that the "avalanche of new remedies is overwhelming us," is unfounded.

An American author, whose specialty is therapeutics, and who is just now engaged in a study of hypnotics, gave us his estimate of this class of agents in a conversation recently; we quote his views in our own words:

"The only new hypnotic introduced during the last ten years is pello-tine; its value is not yet established, although several favorable clinical reports have been published; nothing valuable therapeutically has been heretofore gained from the cactus plant. Trional, introduced recently, is only an improved sulfonal (dating back more than ten years), and the two are equally dangerous. Chloralamid is the next recent introduction, and *is the safest of all*; but even chloralamid can induce a habit, although few cases are on record; it is least poisonous, and patients have recovered without damage from enormous overdoses.

"All the new hypnotics can be used successfully in some cases properly administered. Chloral and chloralamid appear to yield the best and most reliable results, while least exposing the patient to dangerous symptoms. The ideal hypnotic is still to be attained."—[Editorial in *The American Therapist*, August, 1897.]

THE TOP OF THE OZARKS.



HAVING become tired of a big, smoky city, wearied by the constant noise and strife, I wanted a rest; and, in truth, it was needed. Where should I go? there was the rub. I could go almost anywhere, but the question was: Where could I secure complete change of air, scene and surroundings? I had been told by enthusiastic friends that a little town named Eureka Springs, nestled in the Boston mountains in Northwest Arkansas, was just the place. So, to Eureka Springs I went. Leaving St. Louis in the evening, via the magnificent Frisco railway, at 9 o'clock the next morning Eureka was reached.

Current art shows some queer towns perched among the Alps. None of them are more remarkable than this Arkansas city. Wherever a goat can travel there is a street. When it is not a street it is at least a path.



THE TOP OF THE OZARKS.

Straight lines are unknown. Shelves and terraces are everywhere. There is probably not a single level site for a house in the town, and not one has been built with the same level at both ends. The gulch the railroad has been made in opens out into branches, like the toes of a bird, and these toes are all on a widely differing elevation, and each one of them is a street. Between these streets the houses climb and perch, at all angles and elevations. Some of them seem inaccessible, and one goes by devious paths

and back ways to get to them. No view of the place ever made or published conveys any idea of it. No mountain side in Colorado has such a cluster of human habitations. There is no reason for its existence in such a locality, no usual cause why it should grow amid such surroundings, clinging to the sides of ragged canyons and in the midst of a formless upheaval of rock and fissure.

Yet Eureka Springs has about 6,000 people, besides hundreds of visitors. Without manufactures or commerce beyond such as is common to that many people everywhere, it still exists. And there is a reason—Water.

Water made the place and brought the people, and led the railroad from the station on the Frisco line down the gulch and into the town, and



PRIMITIVE RESIDENCE. EUREKA SPRINGS.

built the pretty churches and the residences that cling to the mountain sides, and graded and leveled the curious streets, and constructed a sewer system, and supplied gas and an electric plant and a remarkable street railway, and placed on its splendid eminence overlooking a mountain world the beautiful hotel known as the Crescent.

There is climate, it is true, one of the most charming of the latitude, where even the usual gales of March are unknown, and which to the northerner is southern, and to the southerner is northern all the year. But climate is widely scattered, and is not alone sufficient to produce the known results. Everybody talks of the waters; the testimony is on every hand and the evidence of efficiency is plentiful and remarkable. Eureka Springs is either a great faith cure or one of the most remarkable water cures of these times. Men tell stories of cures, for themselves and others, which seem to the visitor almost incredible. Educated physicians describe their own cases and the cases of others, and enumerate diseases, known to be

ordinarily incurable by medical science, which have here been cured. Crowds cluster at the springs and drink persistently. Everybody owns a cup and a jug. No invalid does anything more than sit and gaze across the mountains, and walk slowly up and down these steep inclines, and drink the waters.

And now comes the singular fact, in answer to all inquiries about ingredients and curative agencies in these waters, that there are none. Chemistry, which is the field of the highest development of modern applied science, gives as the result of analysis almost pure water. In a gallon, 231 cubic inches of the water, there are *less than six grains* of chemical ingre-



THE BASIN SPRING, 1897.

The Original Basin as Cut by Unknown Hands in Prehistoric Times.

dients. The highest attenuation of homœopathy scarcely attains to such an extreme dilution.

Here is the analysis:

Each gallon of 231 cubic inches contains:

Chloride sodium	0.19 grains.
Sulphate soda	0.09 grains.
Bicarbonate soda	0.15 grains.
Sulphate potash	0.13 grains.
Bicarbonate lime	4.43 grains.
Bicarbonate magnesia	0.47 grains.
Iron and alumina	0.08 grains.
Silica	0.31 grains.

Total..... 5.85 grains.

Free ammonia	0.14	} Parts in million.
Albuminoid ammonia	0.07	

The gas contained is 28.52 cubic inches in each gallon of water. It

is worthy of note that the gaseous contents of the water of Eureka Springs is remarkable from the fact that there is a large proportion of nitrogen. The large proportion of nitrogen is proof of a proportionately large amount of oxygen.

If a mysterious combination is the secret, it has defied investigation. No physician and no patient knows precisely *why* these waters cure. When the facts are all known the question still remains unanswered, unless it be answered thus:

First.—Pure water is a solvent, the greatest nature furnishes for her own processes.

Second.—The water at Eureka Springs is cool, pleasant, and may be and is taken in unlimited quantities without lasting unpleasant results. It



A STREET IN EUREKA SPRINGS.

acts as a laxative temporarily, after considerable quantities have been taken for a considerable time.

Third.—There is almost no pure water, in any large quantity, in nature. It has always beneficial results when it is found and extensively drunk. It is the largest single factor in healthy digestion, assimilation and excretion.

HOTEL ACCOMMODATIONS AT THE SPRINGS.

Every grade of accommodation can be found here. The beautiful and home-like Crescent Hotel, constructed entirely of native stone and nearly fire-proof, which occupies a most commanding position, gives those desiring

the best accommodation all the room and attention they want. This hotel is said by those who have enjoyed its hospitalities to come nearest to the ideal home of any resort hotel in America. This famous hotel is now



WINDING ROAD BEHIND THE CRESCENT HOTEL.

under the management of John Oliver Plank, who represents the interests of the Frisco Hotel Company.



A CORNER OF THE GROUNDS. CRESCENT HOTEL.

Then for those with smaller purses, but desirous of a first-class house, the Southern Hotel, a commercial as well as tourist hotel, offers accommo-

dations good enough for any one. This hotel is beautifully situated, within a short distance of the famous Basin Spring. W. E. Beatty, its proprietor, has made his hotel one of the pleasantest in the city for the visitor.

Those who go to Eureka are not always sick. Many who are ill recover and then stay on. Returning health and an easy-going horse are cotemporaneous. All the afternoon and late into the evening one can hear the clatter of the hoofs, and the commonest scene is the group of women with flushed faces and wind-blown hair who gather on verandas and tell each other where they have been and what a delightful how-many-miles it was.

And, if any were needed, there are places to go. The reader will understand that it does not matter in the least about this. To go, to ride, to be out of doors—this is the only thing really.



OLD ARKANSAS. FARM NEAR EUREKA SPRINGS.

Eureka Springs is exceedingly favored by nature for the successful treatment of disease. What is generally known as malaria is unknown. The flinty soil is porous, none of it is level, the drainage is complete.

The place is nearly 2,000 feet above sea-level. It is sometimes cold in winter, in the opinion of those who have always lived in the latitude and who do not understand the term as a resident of the north does. It is also sometimes warm in summer, and yet it is a cool and bracing health-and-pleasure resort to all who come from the south.

The result is that the northerner is charmed with the mildness of the winter weather and the reasonable temperature of the summer, while people from the south are pleased with the coolness of the warmest months. The bane of the invalid is climatic extremes—sudden and violent changes. These are unknown.

PUBLISHER'S DESK.

Campho-Phenique.—Extract from a letter received from Dr. H. M. Starkloff, St. Louis, Mo., May 10, 1897, says:

“It affords me great pleasure to state that I have used campho-phénique, in its liquid and powdered form, very extensively, and it has given me more satisfaction than any other remedy, in all cases of wounds, ulcers, and carbuncles.”

Sanmetto in Cystitis, Prostatitis and Gonorrhœa, and in all Irritability and Inflammation of the Genito-Urinary Tract.—In my practice the administration of sanmetto has given excellent results. I have found it unequalled in cases of cystitis and prostatitis, and all cases of irritability and inflammation of the genito-urinary tract. In many cases of gonorrhœa I have used it with excellent satisfaction. I am pleased to recommend sanmetto to the profession as a preparation which has proven invaluable to me in treating the above named conditions.

Jackson, Mich.

C. W. SHAVER, M. D.

Sanmetto in Gonorrhœa with Epididymitis—Also in Specific Vaginitis with Salpingitis, etc.—I take pleasure in testifying to the admirable therapeutic effects of sanmetto. I used it in a case of gonorrhœa with epididymitis, and the result was, if I may say, astonishing. I also used it in a case of specific vaginitis followed by the usual sequelæ, salpingitis, etc., and the symptoms were very much ameliorated by its use.

Columbia City, Ind.

J. W. WORDEN, M. D.

The Following Letter from H. B. Maben, M. D., Gynecologist and Surgeon, No. 28 Main St., Kingston, N. Y., Explains Itself.—The Hall Capsule Co., Cincinnati. *Gentlemen:*—Your agent for Anderson's vaginal capsules called on me to-day and I procured a fresh supply. I have used the capsules almost daily ever since they were first made and find them in every respect satisfactory. I direct patients that I cannot see daily to saturate the cotton with a medical solution and introduce the capsule, which saves much time to myself and is quite as satisfactory to the patient, with equally good results. They serve as a pessary, with healing properties unlike any other mechanical support, which usually irritates and is uncomfortable. They can be introduced and kept intact where the perineum has been lacerated and the ordinary pessary will not remain. In all the ordinary diseases of the vagina and cervix, where a simple application is desired, I know of no means as a vehicle so cleanly and convenient as the Anderson capsule.

Will you kindly send me a copy of your pamphlet, “Woman and Her Diseases.”

Respectfully yours,

H. B. MABEN.

Extract From an Article Written for the London Lancet, by M. K. Hargreaves, M. D., 49 Weymouth St., W. London, England.—He refers to the Anderson Vaginal Capsule, made by the Hall Capsule Co., of Cincinnati, as follows:

These capsules are designed for the introduction of medicated cotton into the vagina, and are convenient, simple and cleanly; they prevent the medicament from being pressed out from the absorbent cotton during introduction; thus gaining the advantage of retaining the full strength of the ingredient used, and avoiding the annoyance to the patient of exposure or soiling the underlinen.

They can be used in all cases of diseases of the vagina and cervix uteri for exhibiting local remedies, and also act as a capital support to the uterus in prolapsus, malposition and relaxation of uterine ligaments and atonicity of the vaginal walls. Unlike mechanical pessaries, they do not cause irritation, congestion, chronic inflammation or uncomfortable feelings; but they have both curative and healing properties, with facility of application.

I have used them for some time now and find them superior to any other means I have yet tried for local medication and as a support to the uterus; for any known remedy can be employed, whether astringent, sedative, antiseptic or alterative. I have used them with success in leucorrhœa, vaginitis, ulceration of cervix uteri, etc., and have found them eminently serviceable.

I beg to call the attention of gynecologists and general practitioners to the great advantages of these capsules over all other forms of local medication.

M. K. HARGREAVES, M. D.

Kryofine.—Like phenacetine, a phenetidin product, this drug differs in being more soluble in the body and hence more powerful and prompt in its action.

In alcoholic caustic potash solution, and also in hydrochloric acid, a much smaller proportion of the former drug is saponified than of Kryofine (the ratio being 10 per cent. to 60 per cent.). It is well known that in the organism these products must be saponified by the acid of the stomach and the alkali of the intestines. Clinically these tests have been verified by a number of competent observers, and more particularly by Professor Eichhorst, of Zurich, who finds Kryofine superior to any coal-tar product, both as an antipyretic and as an analgesic, especially as scientific observation shows that under its influence the blood pressure in the radial artery rises and dirotism disappears. The drug was used with markedly favorable results, even in cases of advanced phthisis and in ulcerative endocarditis. It is administered in doses of four to seven and one-half grains, and in the latter amount, three times a day, was found to give a more prompt, decided and prolonged relief from the intense pains of alcoholic polyneuritis than either sodium salicylate, phenacetine, antipyrine, or exalgine. Kryofine, therefore, would seem to lack, at least to a large extent, those deleterious effects which are so objectionable in other members of the coal-tar series.

Hypnotic Magazine.—The *Hypnotic Magazine*, Chicago, is filled with exceedingly interesting and well-considered articles upon suggestive and electro-therapeutics, now occupying a large place in the thought of the profession.



THE BREAKFAST.

THE TRI-STATE MEDICAL JOURNAL AND PRACTITIONER.

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Vol. IV.

ST. LOUIS, MO., DECEMBER, 1897.

No. 12.

THE DOCTOR'S CROESUS. A TALE OF A GENEROUS PATIENT.

By DR. G. FRANK LYDSTON, of Chicago,

Professor of the Surgical Diseases of the Genito-Urinary Organs in the Medical Department of the University of Illinois.



DOCTOR WEYMOUTH was at dinner when I arrived—he had been detained quite late by his calls, and, as he expressed it, was now attending to his most exacting patient—his stomach.

His colored boy, Pete, announced my arrival and returned with the message that his master wished to see me in the dining-room. I found the doctor eating his repast in solitude.

“Ah, good evening, sir,” he said; “I am more than glad to see you. Mrs. Weymouth went to a ladies’ reception this afternoon and has not yet returned; consequently, I was beginning to be a bit lonesome. Will you not join me? I have but just begun my dinner.”

“I thank you, doctor,” I replied, “but I have just arisen from the table myself, and could not possibly do your hospitable board full justice.”

“Oh, well,” said the doctor, “you will at least partake of a cup of coffee—there’s always room for that you know. Besides, I want you to keep me company for digestion’s sake. And, by the way, I haven’t had

time to glance at the evening paper yet—would you mind looking it over and reading anything that seems interesting?"

"Why, I should be glad to do so, sir," I replied.

After scanning the headlines for a moment I turned to the editorial page and said, "Well, doctor, I don't see much in the news columns that I would consider interesting, but here is an editorial that may please you."

"Ah, indeed!" said my friend; "pray read it."

I then began reading an article on the crime problem in which the prevalent methods of criminal reform and punishment were vigorously denounced. Doctor Weymouth listened attentively. When I had finished reading, he said:

"Why cannot some of our millionaires spend a little of their wealth in damming the flood of criminality? With all due respect for the magnificent universities some of them have endowed, they might do humanity at large much more good in the manner I suggest. We have millions for foreign missions, millions for sectarian universities, millions for armies, millions for churches, millions for prisons and law machinery, but nothing to save the waifs of the land—nothing to save the criminal from himself."

"Well," I said, "to digress somewhat, here is an account of one millionaire who knew how to use his money. He gave his physician an annuity and at one time a fee of fifty thousand dollars. When he died, he left a hundred thousand dollars to the doctor, a cool half million to found a medical school, and—"

"Great Scott, boy!" exclaimed the doctor, excitedly; "let me see that paper!"

I handed the paper to him, and after reading it eagerly for a moment he said disgustedly: "Of course, it had to be a man who was never heard of, and who lived in a town that was never on the map! That's the way it always is. But then, newspapers must live, I suppose, and startling novelties are necessary even though they *be* 'faked', as they say in press parlance."

"Why," I said, "are such generous people so very rare?"

"Well, my dear boy," replied the doctor reflectively, "I have been in practice over forty years, and I have met but one such, and that was many years ago."

"Oh, please tell me about him! I know there must be a story connected with the case."

"Yes, there *is* a story, and I will try to relate it. It is a long one, however, and you must prepare to be bored."

"Oh, I'll take my chances," I replied.

The doctor lighted his oriental pipe—a special weakness of his—and began his story:

"During the first ten years of my practice, in Chicago, I was located in a neighborhood that was neither stylish nor prosperous. The people were of the poor but honest type so often seen among the laboring classes. Their means were limited at best, and although ever ready to pay their obligations, dollar for dollar, they were often in distress during idle periods in the great factories and workshops. Once in awhile—too often altogether—a strike would strain their endurance to the utmost limit. Whenever financial clouds did arise, the doctor had pretty poor picking, I

assure you. Notwithstanding all this I was very fond of my patients, and, to be frank with you, I often think that I would enjoy changing from my wealthier patients, with their whims, caprices and often indifference to everything except their own selfish interests, back to my old *clientèle* of sturdy, honest, well-meaning mechanics.

“But I was worked hard in those days and fat fees were an unknown quantity in my neighborhood. You may therefore imagine with what joy I hailed a call that I received to go to Springfield, to visit a prominent man whom I knew would be willing to compensate me liberally for my journey. The prospect of a day’s absence from my usual drudgery was inviting, and it was with a feeling of intense satisfaction that I boarded the train which was to bear me to my wealthy patron.

“But my patient forgot to wait for me—he deliberately, and with malice aforethought, died, and on my arrival I found my fond hopes blasted. It was evident to me that even nature rebelled against my efforts to market my services to advantage. There was no earthly reason for that invalid to die just then; he had been sick long enough to have gotten his hand in, so that a day or two more ought not to have made any difference to him.

“After some little difficulty I managed to convince his friends that it was not my fault that the man died, and that they ought to compensate me for my trip, even though he had conducted himself in such an unheard of and discourteous fashion. The compensation received was by no means liberal, and it was consequently in no enviable frame of mind that I started for home after my fruitless trip.

“I had gone to Springfield in the morning, hence was enabled to start for home the same day. I boarded a train at ten o’clock that night, and being quite fatigued requested the porter of the sleeping-car to make up my berth at once. As is usually the case, the negro was very slow in getting my quarters in shape, and by the time my berth was ready I was almost too sleepy to climb into it. I finally succeeded in doing so, however, and with a grunt of satisfaction settled down for a comfortable night’s sleep.

“‘Ah!’ I thought, meanwhile twisting the abridged editions of pillows into a hard knot and planting my weary head thereon, ‘there’s one redeeming feature about this useless errand: I will at least have a continuous night’s sleep. For the first time in several years my peaceful slumbers will not be disturbed by that abominable night-bell or the voice of some pestiferous messenger yelling through that invention of the devil—my speaking-tube. The reflection was such a pleasant one that I actually smiled at the heavenly prospect—and, smiling, fell asleep.’

“I do not know how long I had slept—it seemed to me that my eyes had scarcely closed—when I was startled by a voice at my ear and a man’s hand that was vigorously shaking me by the shoulder.

“‘Doctor! Oh, doctor! wake up, won’t you, please?’

“I gave a start, rolled over and sat up so suddenly that my head bumped upon the berth above with a resounding whack! Rubbing my eyes in an almost futile endeavor to pry them open, I recognized the face of the sleeping-car conductor, who was peering at me through the half-open curtains of my narrow apartment.

“‘Pardon me, sir,’ he said, ‘for disturbing your rest so unceremoniously,

but I understand that you are a physician, and I have urgent need of your professional services. A gentleman in the forward car has been suddenly taken ill. Will you kindly come and see him?’

“‘Why, certainly, sir,’ I replied; ‘not having expected any professional calls to-night, I was a bit confused at first. However, command me; I am only too glad to be of service to you—medical men, you know, are always on duty.’”

“‘You are certainly very kind, sir,’ said the conductor; ‘I disliked to disturb you, for you were sleeping at the rate of forty knots an hour. But, you see, we conductors are burdened with great responsibilities, and I shall be very glad to share this particular one with a physician.’”

“‘I was ready in a moment—an old war-horse gets into harness as quickly as automatically—and accompanied the conductor.’”

“‘I was ushered into the drawing-room of the forward car and into the presence of my patient, a gentleman about sixty years of age, who was apparently suffering severely with some abdominal trouble. So extreme was his agony that I at once administered a hypodermic injection of morphia—which, to tell the truth, constituted the entire extent of my medical resources just then, for I had no medicine case with me. My patient was soon relieved and able to talk about himself.’”

“‘Come, sir,’ I said, ‘tell me something about your case. This is certainly not the first attack of the kind you have had. When did your trouble begin?’”

“‘Ah! that is a long story. You are right, doctor; this is by no means my first attack, though how you divined the fact I do not know.’”

“‘My first spell occurred about five years ago. I had been dining out, and had probably eaten and drunk more than was wise—a very human failing you know, doctor. Be that as it may, however, I was suddenly seized with a terrible pain in the pit of my stomach—epigastrium, I believe you medical men call it. This pain seemed to dart about in my right side and was associated with some nausea and faintness. Just as you see me now, my skin was bathed in a cold perspiration, and, taken altogether, I was decidedly the worse for wear. I finally vomited, and after having taken some morphia internally, and applied some hot turpentine applications to my abdomen, I recovered.’”

“‘The doctor who was called to attend me, informed me that my case was one of acute indigestion and would probably not recur if I was careful in my diet. I am sorry to say, however, that your *confrere* was wrong; the attacks *have* recurred about once a month ever since. I have consulted at least a dozen physicians, and have had opinions as varied as the complexions of those who have given them. I have swallowed medicine enough to stock a drug store, but have never been benefited in the slightest degree; indeed, the attacks are getting worse, and were it not for morphia they would have worn me out long ago. Had I not been possessed of some means my pocket-book would long since have become exhausted.’”

“‘But with so many diagnoses to select from, I have probably received the *quid pro quo*. “Neuralgia of the stomach, intestinal colic, gravel, acute indigestion, congestion of the liver, twisting of the bowels”—fine assortment, eh, doctor? One gentleman said I had an aneurism, whatever that may be.’”

“The only diagnosis that has ever really pleased me was one which was made by a gentleman in Washington—I am a member of Congress, by the way, and have been taken ill several times while attending the sessions.’

“‘Ah, indeed!’ I said; ‘and what was this remarkable opinion?’

“‘Well, I was advised to consult a gentleman who was said to have a sort of divining-rod capacity of diagnosis, and although somewhat disgusted with my previous experiences, I yielded to the importunities of my



friends and visited him. He wrote down an encyclopædic history of my troubles, and finally, after very profound reflection, assured me that my case was one of “pure neurosis, sir—pure neurosis.” I endeavored to get some satisfactory explanation of the term “neurosis,” but, as my fee was already in the doctor’s basket, the attempt was a failure. Having had more display and bigger words for my money than ever before, I nevertheless felt I was in duty bound to be satisfied.’

“‘Tell me,’ I said, ‘have you ever been jaundiced—has your skin ever been yellow after these attacks?’

“‘Why, since you mention it, doctor,’ replied my patient, ‘I believe my friends have from time to time called my attention to a slightly yellowish tinge of my eyes and complexion after these spells, and I have myself fancied recently that my skin was becoming habitually sallow.’

“After asking a few more questions regarding his physiological functions, I said:

“‘And now, sir, if you do not mind, I will examine you more in detail.’

“‘Pray do so, doctor,’ said my patient, ‘I am quite fond of new opinions—an acquired taste, you know,’ and he smiled somewhat cynically.

“‘As I laid my hand on the region of his liver and epigastrium, he said: ‘Ah! there’s the spot! Ouch! by Jove, doctor, you have certainly found something interesting, to me at least.’

“‘And to me, also,’ I replied; ‘there seems to be a slight swelling here just below you ribs.’

“‘Why!’ he exclaimed eagerly, ‘I have sometimes thought there might be a tumor of some kind there, but my physicians have assured me I was mistaken. If present at all, however, it has not been constant, for at times the trouble has seemed to disappear entirely.’

“‘Well,’ said I, smilingly, ‘patients do sometimes deceive themselves; but this pear-shaped swelling seems to speak for itself.’

“‘I finally completed my examination and said: ‘Now, sir, I suppose you want a candid opinion in regard to your condition; am I correct?’

“‘You most certainly are, my dear doctor. I feel that you have given me the only thorough examination I have ever had, and I am impressed with the idea that we are on the right track at last.’

“‘Well,’ I replied, ‘Mr. ——’

“‘Throckmorton, John Throckmorton.’

“‘Very well, Mr. Throckmorton, you have just been experiencing an attack of gall-stone colic. Your gall-bladder contains in all probability one or more gall-stones, and has become secondarily inflamed, distended and thickened, and during these attacks its duct is temporarily obstructed by inflammatory swelling. Fortunately for you, the ducts of the gall-bladder and liver proper have not yet become completely occluded by an impacted stone, but such an accident is likely to occur at any time. Your attacks are due either to the passage of a small stone, or to the temporary wedging of a stone in the mouth of the duct. As the stone slips back into the gall-bladder or on into the bowel, the pain is immediately relieved. I presume you have had attacks that have passed off without morphia, have you not?’

“‘Yes, yes!’ he exclaimed eagerly; ‘I have several times been so situated that I could get no medical assistance, and the attacks finally passed off as suddenly as they came. Oh, I am sure you are on the right track, doctor; how fortunate this illness has proven, to be sure!’

“‘That remains to be seen,’ I said, smiling at his enthusiasm. ‘No physician is infallible. You should appreciate that fact, for it is probable that you have consulted some very competent men. You observe, however, that there has been a wide variation in opinions. Like every other sick person, you are inclined to be over-enthusiastic on receiving an opinion that coincides with certain impressions of your own in regard to your case; this is a common failing.’

“‘You are certainly modest, my dear doctor, and it is quite charitable in you to compliment your predecessors in the case; but, all the same, I don’t think much of their intelligence.’

“‘Oh, well, sir,’ I replied, ‘it is possible that none of the physicians who have seen you have had as good an opportunity to analyze your case as I have; it is always the last man who makes the diagnosis; he has

the failures of his *confreres* to guide him, and very often his success is simply a victory of "hindsight" over foresight. Then, too, Mr. Throckmorton, you must remember that doctors are not to be judged by isolated cases of either failure or success, but by average results.'

"But what of the man who said I had a—oh, yes, a "neurosis?" Why, his office looked like a Chinese junk-shop, and I *know* that about half his maneuvers were for effect alone.'

"I was discreetly silent."

"Humph!" he exclaimed, 'your indulgence of other physicians' mistakes and peculiarities does you credit, but it is not very entertaining. I might say, moreover, that you are somewhat different from some of the others whom I have consulted. They were very—what do call it, ethical, eh?—and wouldn't criticise the other fellow for the world, oh, no; but before they got through with me they always managed to give me to understand that, while nature was mainly responsible for the imbecility of their predecessor, the latter was an ass, just the same.'

"Yes, my dear sir,' I said, warmly, 'but such men do not represent nor possess the *esprit de corps* of the body medical. I am proud to say that the majority of men in my profession are dominated by high-minded principles; they are men who, modestly recognizing their own weaknesses and mistakes, have the kindest charity for the errors of others. Why, sir, there is not in all the world, a nobler man than a courteous, scholarly, high-principled, self-respecting physician!'

"You charm me, doctor, and I would gladly hear more of your ethical ideas, which, quixotic as they may at first sight appear, are certainly inspired by the milk of human kindness and as broad as the mantle of charity; but we will probably have an opportunity for social intercourse on some future occasion. And now, doctor, what treatment do you suggest in my case?"

"Well,' I replied, 'what has been your impression with regard to the drugs you have taken; do you think you have had much encouragement to continue dosing?"

"I should say not, my dear doctor—ugh! the very thought of medicine makes me sick! Still, there may be something that has not yet been tried.'

"Now, sir,' I said, 'listen to me: It strikes me that I would be very foolish to repeat the experiments which have already been made in your case. My *confreres* have greatly aided me by trying all sorts of drugs upon you. If anything was to be hoped for from medicines you would have been benefited by somebody or other. There is no wonderful drug which, by a mysterious property of selection, can be relied upon to act upon those concretions in your gall-bladder.'

"Then what in heaven's name am I to do? Is there nothing that can be done for me?"

"Most assuredly there is,' I replied, 'for, although medicine promises you nothing but further nauseous experimentation, surgery offers you—a cure. An operation, with our modern methods, will be pretty safe, and unless malignant disease—which is sometimes caused by such conditions as are present in you—has already developed, a good result may be expected.'

“But what of the danger?” inquired my patient. “Is not the operation a very hazardous one?”

“Well, sir,” I answered, “no operation is absolutely devoid of danger; but the one your case requires, while not entirely free from risk, is now-a-days one of our safest procedures—always providing the patient allows his surgeon to select the most favorable time for the operation. Where the operation is deferred until impending death compels interference, the mortality rate is of course high.”

“Mr. Throckmorton quietly reflected for a moment, and then asked: ‘Are you engaged in the class of work under consideration?’”

“I am, sir.”

“And where are you located, Doctor ——?”

“In Chicago. My name is Doctor Weymouth—pardon me for not introducing myself before,” I replied.

“Well, Doctor Weymouth, you will please consider that my case, from now on, is entirely in your hands. I had intended to go through to New York to-morrow, my final destination being Carlsbad. I will, however, stop off in Chicago, have an operation performed, and go abroad after I have recovered. The waters may be excellent in winding up my case. And now, sir, permit me to compensate you for your valuable assistance and advice. I do not know what your fees are, but pray accept this on account, at least. I do not carry much ready money with me, but I can give you the balance as soon as we arrive in Chicago.”

“While saying this, my grateful patient extracted a huge roll of bills from beneath the pillow of his berth, counted out five one hundred-dollar bills and thrust them into my hand! I maintained my composure by a tremendous effort, and by the exercise of almost superhuman self-control I managed to appear as though five hundred-dollar consultation fees were an every-day experience with me. I didn’t examine the bills critically, but nonchalantly shoved them into my trousers pocket. The pocket, I fancied, gave a yelp of astonishment and delight, but my patient didn’t hear it. After pinching myself a few times to determine whether I was alive or not, I was about to retire, when Mr. Throckmorton said:

“Now, doctor, I don’t want to impose on good nature, but I do wish you would remain and chat awhile. Morphine always makes me wakeful, and I shall be quite in misery for several hours unless I have company. I want you to consider it strictly professional and a matter of business, but pray remain awhile.”

“Why, I shall be pleased to do so, Mr. Throckmorton,” I replied. It was hardly necessary to tell my patient so, but his greenbacks had excited my nervous system quite as much as the morphine had his own. I therefore gladly seated myself on the edge of his berth, and we entered upon a conversation that proved to be very entertaining—to me at least.

“I am very fond of Chicago,” he said, “although I have not really visited that city for many years—I have merely passed through the place on my way to and from Washington. The city has almost outgrown my recollection. You see, I lived there for a few years as a young man, but not being successful I went west to seek my fortune, and found it in large quantity in the gold mines of Colorado. I came east this time by way of St. Louis, having some business with a syndicate there, and should have

gone through without going to Chicago, had not my daughter—who, I forgot to state, is traveling with me and is in the next compartment of this car—heard from an old school friend who has recently married and gone to Detroit to live. Being anxious to gratify her desire to visit her friend, and at the same time desirous of visiting Springfield and Chicago, I decided to take this *route*. I had planned for an extensive tour of Europe. My affairs are in excellent shape just now. I have no family save my dear daughter, who is twenty years of age, and ought now to see something of the world, so there was no reason why I should not take a little comfort for awhile. I thought of trying Carlsbad first and doing the rest of Europe afterward. I am very, very glad, my dear Doctor Weymouth, that I took this *route*. If I had not fallen in with you I suppose I should never have received any benefit or even hope in my case—still, there may be some very expert physicians abroad.'

“‘Well, sir,’ I replied, ‘the pleasure is mutual. I am duly appreciative of the confidence of a patient like yourself. Such credit as may be due for my diagnosis, however, as well as for the operation which will surely relieve you, belongs not to me, but to American surgery. We have so many competent men in this country that it puzzles me to know how you have missed striking one of them. As for the European doctor—well, he’s all well enough in his way, but, sir, let me tell you something a lot of our fool millionaires and snobs do not seem to know: to American genius is due the credit of anæsthesia and everything in abdominal surgery. American doctors have taught abdominal surgery to the world, yet rich men and women go abroad to have our foreign disciples do work that can be better done by their masters here at home. The American doctor is king, sir, I can tell you that! Why, sir, their biggest man over there, whom I will not name, because I don’t believe either in criticising a brother physician or advertising a foreigner, is not a circumstance as compared with dear old Ephraim McDowell, of Kentucky! That man actually staked his life when he did his first ovariectomy—the first one ever performed! A mob was ready to hang him if he failed! The American doctor first, last, and all the time, sir; that’s *my* motto.’

“‘Bravo! Doctor Weymouth,’ said Mr. Throckmorton; ‘you talk and I presume cut, just as our forefathers fought for the glory of our country. I believe you are right; some of our wealthy men *are* fools, and I fear I was about to join their ranks.’

“‘Well, sir,’ I said good naturedly, ‘I should have tried mighty hard to keep your case in this country. If you had not been satisfied with me I should certainly have referred you to some of my many competent *confreeres*.’

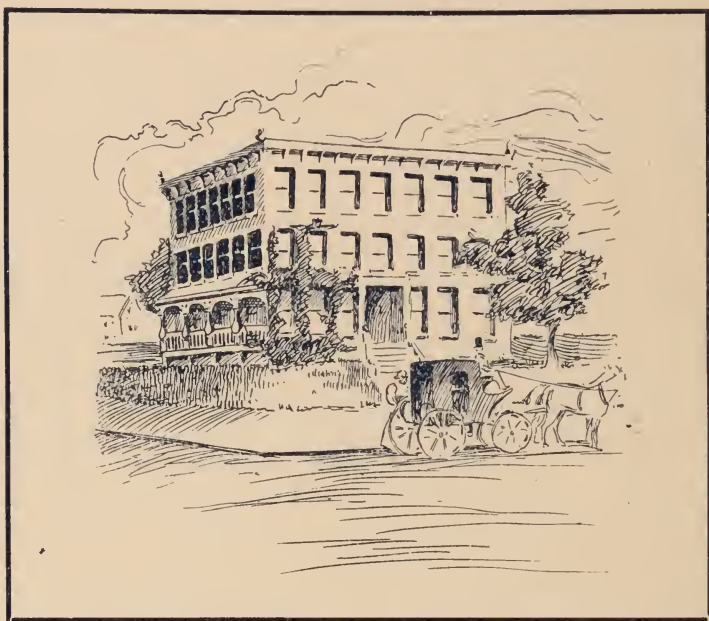
“‘I suppose,’ continued my patient, ‘that you have great hospital facilities in Chicago. Where do your surgeons operate mostly?’

“‘Well,’ I replied, ‘some of our men have positions on the staffs of our large charity hospitals, where they allow themselves to be imposed upon and injure the profession by doing work *gratis* for many people who are amply able to pay fees. The surgeons who submit to this blackmail do so as the price of hospital facilities, and such glory and advertisement as they may obtain from it. Other men have private hospitals of their own—something we all should have. Others, again, are compelled to rely

upon the accommodations afforded by such hospitals as generously (?) permit physicians who are not on their staffs to bring patients to board with them—for a liberal consideration. I am one of the latter class. I am free to say that I have *entree* to several institutions in which my patients get—just what they pay for, if I am sharp enough to insist upon it. As my patients are mainly well-to-do, and many of them have excellent facilities at their own residences, I get along very well—as well as possible without having my own institution.'

“‘But why don't you have a hospital of your own?’ asked my patient.

“I smiled as I replied: ‘There's no obstacle in the way except the lack of financial ability. I may overcome even this some day, but at present—well, you see, we doctors don't get rich so fast as some people suppose.’



“‘What would it cost, doctor, to start a really elegant private hospital?’

“‘Why,’ I replied, ‘about twenty-five thousand dollars.’

“‘Um—a mere bagatelle, sir,’ said Mr. Throckmorton. ‘Doctor Weymouth, if you succeed in my case you may consider a hospital twice as elaborate as you seem to believe essential an assured fact. You shall not only have the finest of hospitals, but a liberal annuity to assist you in its support.’

“‘I thank you, sir,’ I said, as I swallowed a base-ball that seemed to have lodged in my pharynx. ‘I shall be duly appreciative, although my feeble skill does not deserve so munificent a reward.’ With this I drove a large pin into my leg to see if I was still on deck.

“‘You are entirely too modest, my dear doctor,’ he said benignantly,

'and, by the way, now I think of it, there is one little matter concerning our surgical engagement that I very nearly forgot. Professional men are supposed to receive a retainer,' saying which he took a check-book from the repository containing his valuables beneath the pillow, and after a preliminary shake of, and swear at, his stylographic pen, wrote out a check, signed it, and handed it to me with a polite bow. I took the piece of paper in as indifferent a manner as possible, but when I saw the hieroglyphs \$10,000 in one corner I—well, I almost lost my grip on life. I questioned whether it would not be well to whittle my leg with a jack-knife instead of jabbing it with a pin. I feared the latter was not a fair test of my condition.

"I put the check in my pocket-book, however, and thanking the donor as coolly as I could, was about to continue our conversation when a sudden thought struck me and almost took my breath away. What if my patient was—but, pshaw! he talked rationally enough. At the same time the case would bear watching. Meanwhile I must not let him divine my suspicions. I reached over and taking him by the wrist felt his pulse, saying: 'I hope you are not overexerting yourself by conversing too long, sir?' at the same time glancing critically at his eyes. 'Well,' I thought, 'he certainly *looks* sane enough, but I shall not feel satisfied until that check is cashed, all the same.'

"'Oh, no,' he replied, 'on the contrary, I am feeling better every minute; besides, I am greatly enjoying our conversation. I want to know more of you, doctor—and, by the way, now I think of it, are you connected with any medical school? I understand that there are some excellent ones in Chicago.'

"'Yes, sir,' I replied, 'I am proud and happy to say that I have been a teacher in one of our best colleges for some years. Of course, to be loyal, I should say that our school is *the* best in the city; but candor compels me to acknowledge that we have several medical colleges of great superiority and renown. My colleagues feel that our system of instruction is a superb one, but we also recognize the fact that our friendly rivals are among the best teachers in the land.'

"'I presume that the college professors have quite lucrative positions,' he said.

"'I could not help laughing aloud at this. It was evident that my patient did not know much about medical teaching.

"'Why, no, not exactly,' I replied. 'Most of us not only teach without money and without price, but pay roundly for the privilege. The majority of medical schools are supported entirely by private capital and enterprise, and are never profitable ventures. It is supposed by many that the notoriety obtained through medical teaching is profitable indirectly, but I could never see wherein one is even paid for his time.

"'The public, Mr. Throckmorton, demands finely educated physicians, yet does nothing to assist in making them. Every graduate that we turn out is a menace to our own prosperity, yet we are expected to go on educating competitors and paying for the privilege. The result has been financial distress among the good schools, and dishonesty among the others.

"'The foolish public neither knows nor cares where a man has received his medical education—it simply asks whether he is a "doctor" or not, and

then employs him.' The qualifications of the men who enter the practice of medicine vary widely, yet they are all made equal in the eyes of the people by the degree of M. D. and the possession of a State license. Ridiculous, isn't it?'

"'It most assuredly is a very absurd system,' he replied; 'but where's the remedy?'

"'Well, sir,' I said, 'let some of our rich men endow a few medical schools where science can be properly taught to rich and poor alike, and within a few years the public will begin to ask where its doctors were educated. Two evils would then be abolished—mushroom colleges and the yearly influx of foreign-born, half-educated, bumptious, swaggering medical pretenders, who couldn't black boots in Europe, yet speedily gain the adoration—and dollars—of the American public. America might be the fountain-head of medical education, if she were given half a chance.

"'You see, sir, it is a pretty hard task trying to build up a medical school on a high educational plane while struggling under a heavy load of debt. Our faculty have had a dose of that, I can tell you; and yet, I am proud to say, our school has ever been in the forefront of educational progress.'

"'You say, doctor, that your own college is laboring under financial difficulties?'

"'Yes, sir, it is, I am sorry to say.'

"'Well, my dear sir, it shall do so no longer. I will look into the matter as soon as I arrive in Chicago. I have more money than one man is fairly entitled to, and I have often thought I should like to make some endowments *before* I die. I don't believe in leaving such things for one's executors to attend to. I was at a loss for a worthy object, but you have made a most valuable suggestion, sir. Who is nearer the vital interests of the people than the doctor? No one; and no one is better entitled to assistance in obtaining his education. Why, Doctor Weymouth, I am under the greatest obligation to you for putting me in the way of serving such a worthy cause as that of medical education.'

"'You do me too much honor, sir,' I said, modestly, taking out my jack-knife, opening it, and plunging it into my thigh as near the course of the great sciatic nerve as I could. 'But,' I said, continuing under the balmy inspiration of the warm blood which slowly trickled into my boots, 'you will certainly do a great and noble work if you proceed along the lines I have suggested. We can now build the laboratory and hospital we have so long desired. Ah! my dear Mr. Throckmorton, my life has not been a failure! I have at last found *one* man who appreciates, and is willing to further the interests of, the medical profession.'

"'I thank you for the compliment, doctor,' replied my generous patient. 'And, by the way, I have neglected my duty as host, for which I trust you will excuse me.' With this he reached under his berth, brought out his valise, and opening it displayed a bottle of whisky and some cigars. 'I cannot join you, doctor, but pray don't be at all conventional; help yourself, please.'

"I required no persuasion, but set to with a will. As I recall that night, it seems to me that I have never before nor since drunk such ambrosial nectar, or smoked such fragrant tobacco—aye, my dear old hookah,

I mean it! And so we sat, chatting and story-telling, forgetting the passing of the hours, until morning. Mr. Throckmorton proved to be a capital entertainer—so excellent, indeed, that he put my own modest attainments as a *raconteur* to the blush—and the gray dawn of the early morning had almost broadened into full daylight before I realized it. Finally noticing the situation, however, I said:

“Well, well! Mr. Throckmorton; do you know that it is almost sunrise? I am a pretty sort of a doctor, to keep you up all night! I declare, I'm ashamed of myself.”

“‘Why,’ said my host, looking at his watch, ‘it *is* morning, that's a fact—it is half past five o'clock! But, my dear doctor, my only regret is that the night could not be stretched out a bit. Time has slipped by most pleasantly, I assure you. But there is no reason why we should separate until we arrive in Chicago. I intend breakfasting early on the train, and I should like to have you join me. My daughter will be most happy to meet you, I am sure. Ahem! by the way, doctor, I forgot to ask you whether or not you are a married man.’”

“‘Oh, yes,’ I replied, ‘I have been married for several years, and have two children of my own.’”

“I fancied there was a shade of disappointment upon the features of my new friend as he replied: ‘Ah! indeed—that is charming, sir; charming! But what about the breakfast?’”

“‘Oh, I hardly feel that I ought to engross any more of your time just now, sir,’ I replied.

“‘Tut! tut! don't be so modest, doctor. You have been my physician all night, and I really must have you at breakfast as my guest.’”

“‘Well, sir,’ I said, ‘since you insist, I will make my toilet and join you in the dining-car.’”

“‘Very good, my dear doctor; I will have the porter call you when breakfast is ready. What shall I order for you, sir?’”

“‘I will leave that entirely to your own discretion, my dear Mr. Throckmorton, but,’ I said, laughingly, ‘let there be plenty of it and I'll not quarrel with either variety or quality.’”

“Having completed my toilet, I sat down in the smoking compartment and read until the porter announced that breakfast was ‘now ready in the dining-car,’ and informed me that Mr. Throckmorton was awaiting me.

“As you may imagine, my dear boy, it was with some curiosity that I approached the table where sat my generous patient and his daughter. I fear, moreover, that I blushed confusedly as I was introduced to the young lady. It was evident from the look of interest she bestowed upon me that her papa had been singing my praises. This only added fuel to the fire of my embarrassment.

“‘I am very glad to meet you, Doctor Weymouth,’ she said, in a voice as sweet and clear as that of a thrush. ‘Papa has told me how good and kind you have been to him, and the wonderful result he hopes to obtain from your skill, and I am so glad to have the opportunity of thanking you.’”

“‘You are very kind I am sure, Miss Throckmorton; but the pleasure is mutual, I assure you, both as regards meeting your father, and—pardon

me, sir—more particularly the honor of the acquaintance of his charming daughter.'

"'Ah, my dear doctor!' exclaimed Mr. Throckmorton, 'you may be a married man, but you have not forgotten your gallantry I perceive.'

"I fear I swore under my breath. You see, the old fellow *might* have kept his mouth shut on the married part of my history. However, I merely bowed in acknowledgment of the rather disastrous compliment, and in response to Mr. Throckmorton's invitation to fall to, I began disposing of something new to me—a champagne breakfast! As I looked at the profusion of good things my patient had ordered for the repast, I fancied I understood the origin of his gall-stones a little better.



"Never shall I forget that breakfast. Such viands! Such wine! Such jolly conversation, and—such a beautiful girl! 'Ah, me!' I thought, 'why did I ever tell papa I was a married man?' Really my boy—*entre nous* you know; don't you ever breathe a word of this to Mrs. Weymouth—for a few moments I forgot that I *was* a married man! But I was younger then than now, and even a loyal heart is but human, and that girl was *so* beautiful! It seemed to me that I never saw a woman half so lovely. Such a glorious head of rich dark brown hair, with just enough of that lovely Titian reddish tinge to make one wonder whether it was not aglow, eyes of hazel, cheeks like the glow of an autumn sunset, full red lips that recalled sweet Dudu's stung by the bee, hands that would have driven an artist mad, a form as majestic as a Juno's, and a foot—see here, lad, open that transom and let in some air!"

"Ah! my boy, the times that are gone by! they are always—but I mustn't grow sentimental.

"I know not how long we sat at table that morning, but I do know that that breakfast is one of the brightest memories of my somewhat commonplace career.

"But all pleasant things must have an ending, and that memorable meal was no exception to the rule. Miss Throckmorton had just touched her glass of wine to mine, saying, 'And now, my dear Doctor Weymouth, let us drink to our better acquaintance,' when—

"'Chicago! Chicago!'—

"'See hyah, boss, aint yo' all gwine ter git up—Bin shakin' yo' fo' a plum hou', sah—Done pass de city limits half hou' ago.' "

I said nothing when Doctor Weymouth had finished his story; I couldn't just then. I merely wiped away the saliva which, despite my best efforts, was slobbering over my chin. When I finally came to I said, "D——n!"

Doctor Weymouth helped me on with my overcoat and I fain would have thanked him, but I only said, "D——n!" I tried to say good-night, but again—"D——n!" As I hustled along toward home I ran into a man—bang! He caught *his* breath first, and glaring at me fiercely said, "D——n!" "Thank you, sir," I said politely, extending my hand in cordial acknowledgment of his sympathy and his ability as a mind reader.

I finally reached home, and as I slammed the front door viciously behind me, the noise and jar reverberated through the entire house, with a woody, harsh, discordant, thrilling "D-n-n-n-n-n!!!"

A CASE OF HEMATO-CHYLURIA.*

By A. H. OHMANN-DUMESNIL, St. Louis.



ALTHOUGH the recording of rare cases forms an interesting chapter to be added to pathology, there occasionally may be seen some which seem to have so far departed from what is usually seen as to form a real curiosity in medicine. Such is the character of the case I wish to briefly mention. But before proceeding any farther it may not be uninteresting to say a few words in reference to the condition known as hemato-chyluria. It is a condition confined to the tropics, and concerning which very little has been written by medical writers.

Those who have written upon it seem to have confined themselves to a description of the symptoms, the pathology, and the inefficiency of the therapeutic measures employed up to this time.

* Read before the St. Louis Academy of Medical and Surgical Sciences, November 23, 1897.

Chyluria and hemato-chyluria are parasitic diseases in the majority of instances. But the non-parasitic form is a rare affection which occurs in temperate regions and unassociated with the *Filaria Bancrofti*. Whilst chyluria may be occasionally met with, it will be found that it is comparatively rare. The urine has a more or less opaque white color, resembling thin milk. The urine sometimes coagulates into a jelly-like mass, which is rather firm. Blood is occasionally voided with the urine, and then the condition is known as hemato-chyluria. The same conditions are of frequent occurrence in the tropics, and, in those cases, the cause is the *Filaria Bancrofti*, which is introduced into the human system by the mosquito, which acts as an intermediary host. The cause of the condition, when not parasitic, has never been accurately determined, and but little is known of the pathology in these cases.

The case I desire to report occurred in a married woman of thirty-three who had borne two children, the eldest being fourteen years of age. She had had several miscarriages. She was subject to chronic obstipation. Physically, she was weak and somewhat emaciated. She was five feet four inches in height, weighed 116 pounds, and was of a lymphatic temperament, besides being neurotic. Her hair was of an unhealthy blonde color, her mucous membranes pale and her bony frame marked. Pale blue eyes and lack of color marked her features. She originally came to see me for a generalized pruritus, attended by a fine papular eruption, which I determined was purely nervous in origin. Some days after prescribing for her I was called to the residence to see her, as she was bed-ridden. When I called I was informed that she was very weak and passed enormous quantities of urine. I asked the patient to pass her urine at night in a small water-pitcher and keep it for me, as I suspected the condition from the milky color which it had. The next day I called again to observe the urine. I found it to be a jelly-like mass which could not be poured out, but fell out in one mass.

I then asked to have the first urine of that night placed in a half-pint white bottle, which was done, and delivered to me the next morning. The relative quantities of blood, urine and chyle which were present and spontaneously separated were as shown in the diagram. The chyle had a rather oily appearance, although its nature could be easily determined by inspection alone. During all this period the patient was becoming progressively weaker, and insomnia had declared itself. The patient was under the care of a general practitioner from the time I noted the trouble with the urine. The cutaneous trouble disappeared in a few days, but the general symptoms became more marked. In about two weeks she died from general exhaustion. The hemato-chyluria never ceased, and the large loss of blood probably increased the asthenia which was evidently present.

When I obtained the first specimen I handed it to a competent pathologist, but he never made a report upon it to me. Another specimen, obtained a day later, and in all respects similar to the first, I examined carefully, but failed to obtain any evidence of the presence of filariæ. What the condition of the kidneys, or of the thoracic duct, or bladder, or any of the viscera was could not be determined, as a *post-mortem* was refused by the husband.

Ordinary chyluria is not particularly fatal, as patients will live on comfortably for a long time, despite the affection. When due to the filaria it is a much more serious condition, and still more so when hematuria is associated with it. What the cause of either condition is has never been exactly determined; and so far as the treatment of hemato-chyluria is concerned, there seems to be complete ignorance on the subject. No method has ever been suggested, in view of the lack of knowledge of the pathology of the trouble, and all symptomatic, tentative essays have all resulted in abject failures. The solution of this problem certainly offers an interesting field of research in the domain of therapeutics.

THE INCURABLE INSANE.*

By J. H. COULTER, M. D., of Summitville, Iowa.



PERHAPS the burning question before this convention will be the consideration of the question of the care of the chronic and incurable insane in county asylums.

The objections urged against the "County Care System," by those opposed to it, are:

First. That they would not receive as humane treatment in county asylums as in State institutions.

Second. That the prospect of being improved or cured would be lessened.

But they do not discuss the question of economy, which is the last but not least

in importance. In regard to the humane treatment at county asylums, I am unable to see why they may not be treated just as well or, in some respects, better than in a State institution, when we consider that they have been pronounced chronic and incurable, and therefore not in need of the medical attention of a specialist on insanity or diseases of the nervous system.

So far as chapel services, training schools, entertainments, and nurses are concerned, they could all be enjoyed in county asylums if proper effort was made by those in charge of the institutions to secure them. In the matter of the dietary in Lee county, where we have forty-one insane, the bill of fare is as good and abundant as most comfortable homes. The daily average bill of fare would be about as follows: For breakfast—fried meat, fried potatoes, syrup and coffee; for dinner—beef, roast or boiled, vegetables in variety, and sweet milk; and in the spring and summer season the product of a large garden is added to the above dietary.

In case of sickness, the patient is provided with food from the superintendent's private kitchen; and it is to be borne in mind that we do not call it an asylum yet; only a poor-house, where the sane and the better

* Read before the First District Supervisors' Convention.

class of harmless insane are compelled to take meals together, males and females having separate rooms and tables. But in the event of the county undertaking the care of all its chronic insane and erecting new buildings and making proper preparations, this could be largely improved upon.

Another advantage would be that the patients would be nearer home, where they could be seen often by their friends, who would have a much better chance to know how they were treated than if they were from fifty to one hundred miles away; it would remove the item of expense to friends who want to visit them.

Regarding improvements and recoveries, we would have as good reason to expect recoveries as they do in Wisconsin. I quote from the report of the State Board of Control of Wisconsin, that during the past year there were thirty-eight recoveries in the county asylums of that State. Perhaps as many as the State of Iowa can show from the chronic insane. While giving the insane the most kindly and humane care compatible with the reasonable economy due the taxpayer, the question of economy must not be entirely lost sight of. I have a letter from the auditor of the State giving a statement of the amount paid to the State by the county for the past ten years, from 1888 to 1897. In 1888 it was \$5,309.69, and the amount increased progressively each year until the present year, when it is almost double, or \$9,670.25, and the total for ten years \$78,489.08. If the amount keeps on increasing in the same ratio, after five or ten years more we may begin to wonder "where we are at" and the ranks of the insane may be reinforced from among the taxpayers.

The opponents of the "County Care System" concede that patients might be cared for at about one-half or less at county asylums what the cost is in a State asylum. It has been demonstrated abundantly for the past fifteen years in Wisconsin that in county asylums the cost is only about \$7 to \$7.50, while the estimates given by our State institutions figure it at \$14; but that does not cover all, for there is usually a deficiency to be made up each year that reaches well up into the tens of thousands. In a report of the superintendent and trustees of the Marathon county (Wisconsin) asylum, also the Fond du Lac county asylum, they report the amount saved at over 50 per cent. above what the same number of inmates would have cost in a State asylum; and all our Wisconsin reports are about the same, as I take considerable pains to investigate the subject. Now, if Lee county or any other of the same population and taxation could save \$5,000 annually by the method and invest it in permanent improvements at home by building a \$15,000 or \$20,000 asylum and pay for it in four or five years in saving, besides the other advantages to the county, such as employing more labor and assistants, etc., and the benefit which would accrue to the merchants, which would be no small item, why not do it, provided we can do as well as they do in Wisconsin in the care of the insane so far as the humane part of it is concerned?

James E. Heg, a member of the State Board of Control of Wisconsin, in an able paper read before the National Board of Charities and Corrections, in speaking of the Wisconsin system, says:

"For each person cared for in our State hospitals the county to which he belongs pays the State \$1.50 and his clothing bill to the State; for each inmate of a county asylum the State pays the county \$1.50 per week. It

will thus be seen that a county caring for its own insane really gets \$3.25 a week in what it saves and what it receives; \$3.25 a week is about as low as most State institutions are able to care for the chronic insane. Very few, counting salaries, clothing, subsistence, fuel and repairs, are even as low as this. The average weekly cost of keeping the insane in county asylums, counting everything, is about \$1.75. Out of this gain the county asylums in ten or twelve years have paid for their entire permanent investment in land, buildings, improvements and repairs."

Another item in the way of economy would be the transportation of patients to and from the State asylums. The total cost of sending an insane person from Lee county to Mt. Pleasant will average from \$35 to \$40, and in some cases \$50; and in a large per cent. of cases released after a time on parole or sent home as either improved or cured, only to return in many cases, and frequently again and again, with a renewal of the whole expenses, insane commission and all, each time, could be avoided by the county asylum plan.

Another thing that would be of great importance to the State asylums would be that it would make room and give time for the better care and closer scrutiny of the acute cases which might hope to be benefited thereby.

The labor that could be performed by those able to do it would be worth consideration. In the Marathon county (Wisconsin) asylum the value of labor performed is valued at as much as \$2,000 per annum.

I think the Wisconsin system "the system," as it has long since passed the experimental stage and is a thing of permanency, and is reduced to a science. I will read Mr. Heg's paper, which I would advise all who are interested to procure by writing him at Lake Geneva, Wis., as it gives a better outline of the Wisconsin system than I am able to describe.

ACQUIRED NEURASTHENIA.*

By L. R. SELLERS, M. D., of Ft. Scott, Kansas.



THIS IS a functional affection of the nervous system, described in our text-books under several names, such as spinal irritation, nervous asthenia, concussion of the spine, etc. The term neurasthenia is newer, broader, and, as it fails to suggest a pathological condition, is a convenient term to use in this paper. In neurasthenia the cerebrum, spinal cord, and sympathetic nervous system, is either in a state of morbid excitement or of morbid inertia. In one condition the normal motor and sensory functions of these organs are exaggerated. In the other condition those

functions are partially suspended. At the beginning the lesion may be

* Read before the Southeast Kansas Medical Society, at Girard, December 7, 1897.

limited to the brain, the sympathetic ganglia, the cord, or even a section of the cord. But such is the relation between these organs that continued irritation of one will soon produce a like condition in the others. The pathology is obscure. Some writers claim that in neurasthenia we have a congested or hyperæmic condition of the brain or cord. While others are of the opinion that the disease is the result of an anæmic condition of these organs. While either theory might be correct, I am of the opinion that in nearly every patient suffering from this malady the amount of blood in cord and brain is less than normal. The disease is manifested by disturbance in the circulation, respiration, secretion, motor and sensory functions, and various derangements of the sexual functions. From these disturbances arise many symptoms; the most common are tenderness along the spine, headache, fœmication of the extremities, tendon reflexes exaggerated, hyperæsthesia, or anæsthesia, insomnia, hypersecretion causing diarrhœas, or scanty secretion which renders digestion weak, palpitation of the heart, with fluttering pulse, or the heart may beat abnormally slow and labored and the pulse weak, hot flashes, neuralgias, superficial and visceral, sexual impotence. The male neurasthenic is often impotent from reason of total failure of erection. In rare cases, owing to the perverted action of the vasomotor nerves, the vessels of one side of the penis will remain empty, while the vessels of the other side will be painfully congested; this condition produces such a degree of curvature in the organ that intercourse is impossible. In the female neurasthenic sexual desire may be entirely absent, or the desire may be so intensified that the patient is a nymphomaniac. The visceral neuralgias of neurasthenic women are peculiar; the pain is localized, agonizing, and continuous. Such attacks have doubtless been erroneously diagnosed hepatic or nephritic colic. And I now believe that some of my cases of gall-stones, which I met in my early days of practice, were simply neuralgias. The patient may be in cheerful spirits, but more often is despondent and sometimes suffers from panphobia. The disease may be caused by shock, by hæmorrhages, by malnutrition, but the most frequent cause is constant and continued irritating impulses, carried from some organ to the brain or cord: for instance, an irritated urethra, an inflamed prostate, a strained eye, a displaced and irritated uterus, a painful varicocele, constantly sending irritating impulses to the cord, will in the course of time create a morbid excitement in the spinal ganglia, which pervert their functions. Sometimes an irritation may be borne for a season without creating much disturbance, then suddenly culminates in a climax.

I recall the case of a ten-year-old girl. While attending school she complained from day to day of a tired feeling, slight continuous aching of the forehead, tenderness along the spine; she gradually grew paler and more nervous, when one day she suddenly had an attack of hysterical mania. I was called to attend her: found her raving, pupils dilated. In her delirium she fancied that she saw all kinds of horrible things—snakes, tigers, etc.; would attempt biting herself and her attendants who were holding her in the bed. After failing to quiet her with other remedies, I administered a full opiate; this soon tranquillized her. After sleeping a short time she awoke and passed an enormous amount of urine; afterwards slept

well during the remainder of the night. Within a few days she returned to school. During the summer, every two or three weeks, she suffered from a paroxysm similiar in every respect to the one described. I sent her to Dr. Jarrett of Fort Scott for an examination of her eyes. He found some defect in her vision, supplied her with glasses, which put her eyes at rest; from that time on she has had no more trouble, the headache and tenderness along the spine soon disappeared, her general health improved, and at the present time she appears to be in perfect health. This case of irritation of the brain and cord was probably caused by eye strain.

I will mention another case of spinal irritation that was evidently caused by irritation of the urethra. The patient was a county officer, aged about thirty-five. He consulted me about his mental condition. Said that for some time he had been troubled with a tendency to question well-known facts. That if he carefully placed a check in an envelope and sealed it, he would ask himself, "Did I put the check in?" That if he opened the envelope and put the check in another, then the same doubt would recur. That this annoying tendency to doubt constantly troubled him. That if he met an old friend whom he had known for years, he would think, "This is Mr. A." Then the doubt would bob up, "Is this really Mr. A.?" He called again in a week or ten days, and was very despondent; stated that his tendency to doubt everything was growing stronger, and that he was impotent. He then related to me that some months prior he had suffered from a severe and lingering attack of gonorrhœa, but that he had been well of this for several weeks, except that he occasionally had a slight discharge, and sometimes felt a disagreeable sensation in the penis. After giving him a careful examination, I noted that he had a urethral stricture, was very tender over the lumbar spine, pulse rapid and weak; in short, he was suffering from neurasthenia. I prescribed a line of tonics, and treated him for the stricture. In the course of time the urethral trouble was cured, and soon afterward he fully recovered his usual health.

In both these cases the cord and brain were irritated. In one case the irritation commenced in the brain and was communicated to the cord. In the other the irritation commenced in the cord and was communicated to the brain. Among other causes of neurasthenia is protracted mental exertion, anxiety, or any emotion that tires the brain may produce in the organ an exhausted, irritated condition, which is communicated to the cord. The diagnosis of neurasthenia can be made only by exclusion. In all diseases of the cord and brain we have irritation. But each structural lesion has its pathognomonic symptoms, which if absent excludes the disease. Occasionally we are consulted by a patient who has sustained an injury in his back. He carries an accident policy, or was injured in a railroad accident, and has a suit pending for damages, or for the collection of his policy. His attorney has informed him that his spine is seriously damaged, and he is in quest of a doctor who will hold the same opinion. An examination may reveal that the muscles of his back are tender, also tenderness over the spinous processes. The circulation, respiration and secretion are disturbed; the lower extremities may present a combination of anæsthesia and hyperæsthesia; is despondent and apparently losing flesh. After excluding the suspicion that he is malingering, and the pathognomonic symptoms of each and

every structural disease of the cord and brain, we have left a neurasthenia from an irritated cord; probably caused by irritating impulses received for a long time from the strained muscles.

Neurasthenia affects both sexes, and persons of all ages. We frequently meet with it in infants who are passing the period of dentition. In girls from the age of fourteen to twenty. But the greatest number of sufferers are women who are passing the menopause. The first step to be taken in the treatment of neurasthenia is to if possible discover and remove the cause. And in the majority of our cases the cause can be traced to a local disease of some organ. The uterus of the neurasthenic who is passing the menopause is generally found to be enlarged, indurated and abnormally sensitive. The application of Churchill's tincture of iodine to the os and cervical canal, twice a week, and the introduction of tampons saturated with glycerine each night, will reduce the engorgement, and relieve the organ of its morbid sensibility. In young growing girls, suffering from neurasthenia, there is often present a hyperæsthesia of the vulva and vagina. Daily injections of hot water, and the introduction into the vagina each night of a suppository of cocoa butter containing opium and belladonna generally produces a good effect. Defects of vision should be corrected by the oculist. In neurasthenic infants, the alimentary canal should be kept rid of irritating matter, and bromides administered to blunt the abnormal sensibility of the nerve centers. Among the medicinal remedies, arsenic is perhaps the most useful; it appears to tranquillize and invigorate the irritated and exhausted nerve ganglia. A full opiate should be administered to the patient when suffering from a paroxysm of pain or hysterical mania. We should always bear in mind that the disease is one of exhaustion, and endeavor in every possible manner to improve the nutrition of our patients. They can often digest and assimilate more food than they are willing to take, and should be urged to take plenty of proper food, such as milk, eggs, and some of the prepared foods, as Horlick's and Mellin's; these foods are nutritious, and are by many patients relished. Cod-liver oil and hypophosphites sometimes appear to be useful. While the tendency of the disease is to recovery, unfortunately the tendency of the patient is to leave us and employ another doctor, who will promise a speedy cure. The confirmed neurasthenic often severely taxes the patience of the physician. He will go from one doctor to another, and try all the patent medicines, which he says "are highly recommended" in his family almanac. For such a patient we can do but little. But if we are able to retain the full confidence and co-operation of our patient, we can in every case expect to greatly improve his condition and often effect a permanent cure.

Chicago Pathological Society.—The annual address before the Chicago Pathological Society, December 3d, was delivered by George M. Sternberg, Surgeon-General of the United States Army. The subject of the address was "Yellow Fever; Its Etiology and Pathology."

ULCERO-CRUSTACEOUS SYPHILIDE.

By A. H. OHMANN-DUMESNIL, St. Louis.



HOSE who have devoted the slightest amount of thought to the subject will have observed that among the peculiarities of syphilitic processes is the one that each manifestation is extremely sensitive to the environments in which it may occur, and all circumstances seem to affect it either for good or for evil. The meaning of this will be more clearly understood when it is stated that under the terms given above are to be understood the general condition of the individual, which is itself dependent upon his mode of living, general hygienic surroundings and food, and the facilities

obtainable by him for the proper and intelligent treatment of his disease. Should these conditions be disadvantageous the results will, of course, be destructive and entail losses of substance which are apt to prove disastrous. It is more notably during the transition period between the secondary and the so-called tertiary stages that the most serious ravages are noted. Amongst the factors which seem to be the most active in bringing about these depredations upon the tissues by syphilis are to be enumerated alcoholism, filth, lack of sufficient nourishment or poor food, exposure, insufficient clothing, debauchery, and, in fact all those conditions which seem to be the appanages of poverty, carelessness and shiftlessness. It is mainly for this reason that the majority of these cases are encountered in public eleemosynary institutions, and are comparatively rarely seen in private practice. However, it must not be forgotten that neglect is very often apt to lead individuals to permit the trouble to go on unchecked to an equal extent, under the delusive hope that it may get better without treatment; or by the adoption of measures recommended by friends, who "have seen exactly the same condition get well" by using a certain prescription which they recommend and which they know to be efficient. Most deplorable of all is the destructive process progressing despite the strongest misdirected efforts of a physician ignorant of the true nature of the condition.

A general description of the ulcero-crustaceous syphilide is at best a most difficult matter. As the name implies, it is a process whose chief clinical characteristics are ulcers and crusts. This is, of course, indicative of the fact that the ulcers are not deep nor that the destructive action is particularly marked and rapid, as otherwise a greater loss of tissue would supervene and the rapid throwing off of the débris would militate against the formation of crusts. The crusts themselves are of a brownish-red or blackish-red color, somewhat irregular in contour, either touching one another, or separated by considerable intervals of healthy skin, or again by spaces showing minor lesions or scars the result of former destruction.

The crusts are not thick and are somewhat adherent, so that when an attempt to separate them is made some bleeding follows. Whilst, as a rule, the crusts are somewhat thick at their central portion many recur which seem to conform to the floor of the ulcer and are so thin that they rather appear depressed, cup-shaped or convex. The edges may be sharply defined and have a raised border, or they may be irregular, with small crusts adhering here and there. If the lesion be in a hairy part the hairs get matted together, and this tends to increase the destructive process by imprisoning a certain amount of the pus, which seems to have a corrosive action. When the crusts are pressed upon a bloody, fetid pus exudes in greater or less quantity. If one be forcibly torn off there is exposed a bleeding, unhealthy, granulating surface from which a most foul odor emanates. It is in reality a stench which is overpowering and *sui generis* and might well be characterized as a *fetor syphilitica*. If after forcibly removing a crust the exposed surface be not interfered with, another and similar one will form again in a comparatively short time. But every time that a new crust forms the underlying ulceration becomes deeper and its periphery extends. Not only this, but two or more in close proximity may, by this process of extension, coalesce, and the result is an enormous lesion where a small number of comparatively small ones existed.

It may happen that under certain favorable circumstances, such as better food, good hygienic surroundings, better habits and improved circumstances, the condition will heal spontaneously. This is possible, but the probabilities are so small that very little dependence should be placed in such a desirable consummation. If such should occur, however, it will be found that the resultant scar will be depressed and rather thick, with some tendency to be corded or stellate. Such a scar, however, is quite deceptive, for, despite its apparent strength, it will easily break down and ulceration set in in a very short space of time. The most common result observed in untreated cases of the ulcero-crustaceous syphilitide is the ulceration to slowly increase and destroy the soft tissues until the bones become exposed and necrotic and caries occasionally follow. If it be the cranium which is attacked by the process, it is only the outer table which suffers; and yet it is not so unusual a matter to see both inner and outer tables of the skull attacked and, as a result of the process, a complete destruction of the osseous structures with exposure of the dura mater.

A few words on some cases observed might be instructive and aid further in a better understanding of the conditions presented in this process. In Figure 1 is delineated a case in which the process had not yet advanced very far. In this instance, the patient was of cleanly habits and of a rather robust build. As will be noted, upon close observation, the ulceration was not very marked. In only two places did there exist ulceration that amounted to much, and even here the skin was hardly destroyed. Whilst the edges were rather irregular in outline, they were somewhat elevated and indurated, the secretion upon the floor of each ulcer being rather scanty. From the form of each ulcer it is readily surmised that each one was the result of the coalescing of several smaller ones—which was the fact, so far as could be obtained from the uninspired statements of the patient. There may be noted other lesions which are not so marked and presenting here and there very small points of destruction. Crusts are

not apparent anywhere, for the very simple reason that the patient was ordered to take a bath and remove all the crusts previous to being photographed. This gave an opportunity to observe both the form and the condition of the lesions, and thus enabled a clearer idea to be gained of the



FIG. 1. Ulcero-Crustaceous Syphilide of Right Buttock. Early Stage.

actual pathological inroads made by the disease. An interesting point in connection with the destructive lesions is the existence of papules, more or less discretely distributed, which is confirmatory of the fact that the process was in an early stage, irrespective of the time which had elapsed. Beyond the papules just mentioned no other lesions were apparent on the

back; and the left buttock was entirely spared, the right one only being involved. This evidently points to some local irritation as the exciting cause of the trouble, although no satisfactory history could be elicited to confirm this idea. The entire trouble seemed, in this particular case, to

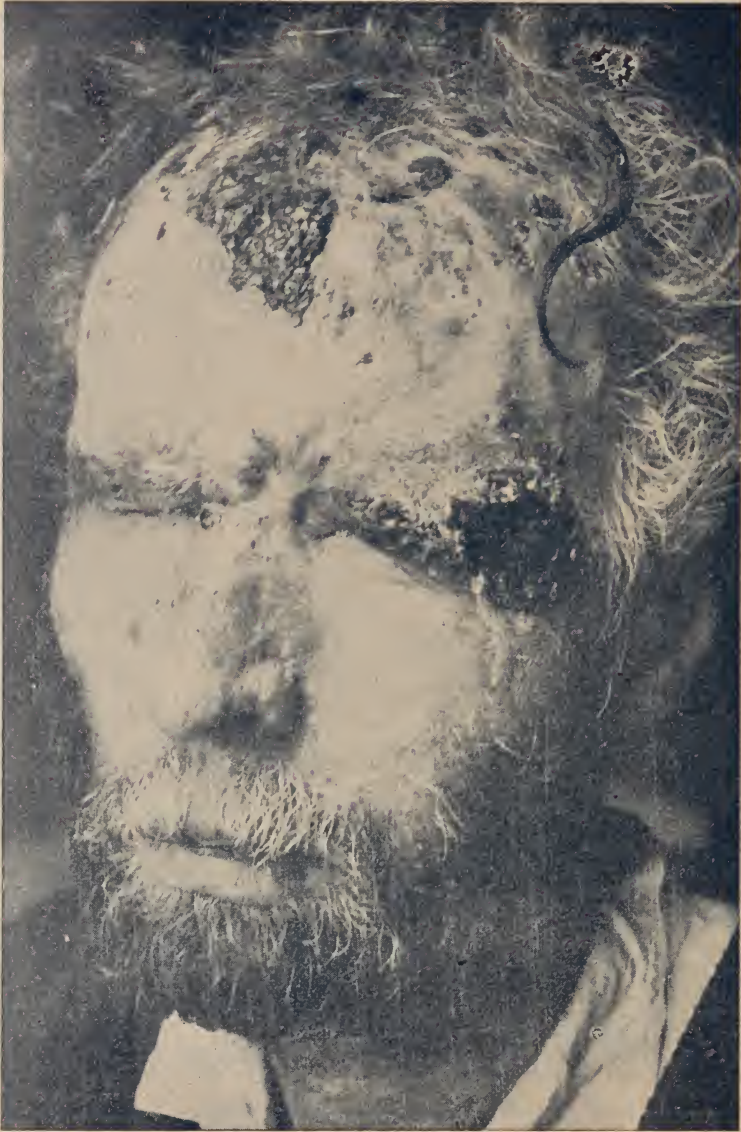


FIG. 2. Ulcero-Crustaceous Syphilide of Face and Head. Advanced Stage.

have been preceded by a greater or less thickening of the skin, evidence of which may be seen in Figure 1, on and somewhat above the right buttock. It does not appear, however, that this is a necessary precursor of the ulcero-crustaceous syphilide in every case.

An example of the advanced stage of the trouble is shown in Figure 2. A comparison of this with Figure 1 will readily show the marked difference which exists between the cases. A mere glance at the picture will reveal a face which shows plainly the marks of dissipation and want of care. The utter neglect of personal appearance is not only plain, but rather accentuated, and the sullen appearance of the features speaks for itself and argues a disinclination to be cleanly and an utter disregard for all tidiness. The unkempt hair and disordered beard certainly speak strongly of the generally demoralized condition of the individual. The bloated features and sodden



FIG. 3. Ulcero-Crustaceous Syphilide of Face and Arms. Destructive Stage.

condition of the skin need no comment. They are but too strongly indicative of the past habits and life which they so graphically represent. The bad condition of the tissues is but too apparent in the appearance presented by the lesions. It will be noted that these are irregular in form as well as in size. In the center of the forehead may be seen a large crust resting upon an ulcerated base, and to its left the remains of former lesions of the same nature. Upon the scalp there exist numerous smaller ulcero-crustaceous lesions which vary in size; and some are in such close proximity that but little time would be required for them to coalesce. Upon the nose may be seen still smaller lesions of a similar nature. Upon the left tem-

ple and encroaching upon the upper eyelid quite a large, ragged ulcer exists, and about it may be seen a thickening of the integument. The skin over the superciliary ridge is also attacked. Upon the lower lip, near the left commissure, a small, shallow ulcer may be observed. Underneath the large crusts, in this case, the outer table of the skull manifested a beginning of destructive action which was made plain by the perceptible roughness found with a probe. Had the numerous small lesions which existed been left to pursue their course undisturbed, the condition observed in the large ones would have supervened. When the patient was photographed he was certainly in a condition which is most instructive to observe. He was in that stage of syphilis which seems to occupy an intermediate position between the secondary and so-called tertiary periods, and yet to draw a sharp line of demarcation between the two would be a difficult task, as shown by the picture.

The form of syphilide of which we are speaking may, in some cases, go beyond the advanced stage shown in Figure 2. In other words, the advanced stage may progress to such an extent that destruction takes place so far as the deeper tissues are concerned. This destructive stage is one which rapidly produces emaciation together with general debility. A marked example is shown in Figure 3. Lesions may be observed upon the face. The left thigh has three marked ulcero-crustaceous syphilides upon its anterior surface: there are three upon the upper part of the left leg and two upon the right. The lesion chiefly demonstrative of the destructive change is that of the left ulna. As the picture shows very plainly, the bone is exposed for some three inches, the joint not being implicated. There is necrosis of the bone present, with indications that caries will soon set in and lead to the separation of a sequestrum. This is not all, for the process has invaded the tibiae to such a degree that necrosis may be expected to take place at almost any time. The changes, however, must not be confounded with the syphilitic ulcer, whose mode of evolution is entirely different and in which the ulcerative process does not tend to lead to deep destruction to the extent that the ulcero-crustaceous syphilide does. This can be easily understood when it is borne in mind that in the former all the secretions have a free escape, whereas, in the latter, the crust forms a covering attached by its edges which imprisons the corroding pus and thus leads to a continuous and deep destruction of the underlying tissues. The fact that such changes occur within a few years of the primary inoculation only serve to emphasize the necessity of constant care and watchfulness in the management of a case. And it further shows, very clearly, that routine treatment is not all-sufficient in this disease, for the patient whose case is shown in Figure 3 had taken what was called a very thorough course of treatment at the much-vaunted Hot Springs, of Arkansas. This is far from being an isolated case, and many will be seen who, despite what some physicians are pleased to call active treatment, have really not been well handled from a therapeutic point of view. As will have been seen by readers of some of the preceding articles on syphilis in this series, the treatment given is generally such as would be looked upon as quite severe, and the doses as enormous, by those who have not had experience or who are faint-hearted in their medication. Of course,

it is not exactly the proper thing to be too rash, nor to give the doses adapted to severe conditions when such as are present are only moderate in degree.

It is an impossibility to obtain the proper care and attention which is absolutely necessary in this class of cases outside of hospitals. As a general rule, individual affected in this manner do not possess homes wherein they could obtain the proper treatment, and even if they did the condition is such an repulsive one that they would be turned adrift to find quarters elsewhere, either in a private or a public hospital. It is a fact, however, that the majority of such cases have no homes whatever and constitute the flotsam and jetsam of the lower classes, more especially in the larger cities. They finally drift into the hospitals when their condition verges upon the desperate.

An absolute necessity in the treatment of such cases is the proper amount and right kind of food, the absolute interdiction of all alcoholics, a sufficient amount of rest, and cleanliness. These having been secured, medicinal treatment will be found to be of benefit. Without them the best directed efforts will be found unavailing. It will be found that a very good internal remedy to administer in the early stage is mercauro, in doses of ten drops thrice daily, increasing gradually up to twenty or more drops, according to the tolerance of the patient. Should this not be available, the bichloride of mercury may be given, in the following mixture:

℞ Hydrarg. bichloridi gr. viij
 Ammonii muriat gr. xij
 Syr. Aurantii cort
 Aquæ destillat aa ʒ iv
 M. Sig.—A teaspoonful in water after each meal.

Later on and in more advanced cases the mixed treatment will be found of benefit. A good working formula is the following:

℞ Hydrarg. bichloridi gr. iv
 Kali iodidi ʒ j
 Essenc. pepsini
 Aquæ destillat aa ʒ ij
 M. Sig.—A teaspoonful in a glass of milk after each meal.

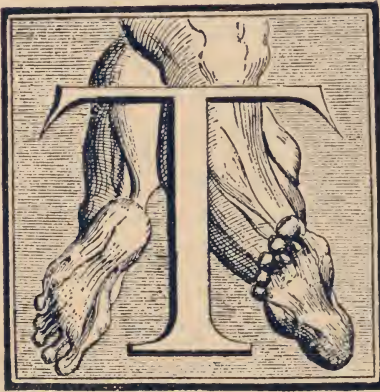
Of course, the individual peculiarities in each case will determine varying amounts in the active ingredients. Should the patient manifest the untoward effects of the medicines, internal medication must be suspended for a short period of time. In many cases it is necessary to administer large doses of the iodides, and it is much better to begin with a large dose than to gradually lead up to it. These iodine preparations should be given in milk, essence of pepsin, or milk of magnesia, to prevent iodism and injury to the gastric walls. A further help in this direction will be found in the administration of bicarbonate of soda between meals.

The local treatment of the lesions is an important adjunct, and it should be thorough. The crusts are to be removed and their bases cleansed with peroxide of hydrogen. They may then be curetted, if necessary, or an application made of a solution of acid nitrate of mercury of the strength of one to eight in water, being very lightly swept over the lesions. Pure nitric acid is also of service, if it be applied by means of a soft pine stick

to avoid any excessive amount. A further aid will consist in the application of a mercurial ointment. The dressings must be repeated as often as the formation of pus exacts, but the cauterizing methods must not be repeated more frequently than absolutely necessary, and, altogether, will not be found to be necessary more than a few times.

RETROFLEXION WITH DENSE ADHESIONS CURED WITHOUT ABDOMINAL SECTION.*

By J. C. MURPHY, M. D., of St. Louis.



THE FOLLOWING is the report of a case showing the result of local treatment in dealing with adhesions between the rectum and the uterus:

Some months ago Mrs. B., aged thirty-two years, presented herself to me for treatment for womb trouble, as she termed it. She gave the following history: Married ten years; one child born to her; infant lived six months. Four years later she aborted in early months of pregnancy; was confined to her bed with fever some weeks after abortion; attending physician informed her that her fever was

due to malaria, but as she was living in Montana at the time, a part of the country where malaria is practically unknown, it is not likely that her trouble was of that origin, but in all probability was the result of puerperal infection. After her convalescence she was left with a profuse purulent discharge from the uterus, accompanied by frequent hemorrhage and much pelvic uneasiness. Shortly after this she took up her residence in New York City, where she was treated by numerous physicians, some of whom suggested an operation. She derived little benefit from treatment. Coming to St. Louis she placed herself under my care. On examination I found a large, soft uterus, retroflexed and bound down to the rectum by a mass of inflammatory adhesions. A profuse offensive discharge was coming from the uterus. The left ovary was much enlarged and tender. The uterus was firmly fixed. I might mention here that the cervix bled profusely where the teeth of a volsellum were introduced. This fact, coupled with the frequent hemorrhage, led me to think that possibly the trouble was of malignant origin. However, I placed the patient on local treatment of ichthyol, fifty per cent. in glycerine. This mixture was applied on pledgets of lamb's wool, which were packed into the posterior vaginal forinx and allowed to remain *in situ* for forty-eight hours, when they were removed by me and the vagina thoroughly irrigated with hot bichloride solution and fresh tampons introduced. The patient being

* Read before the St. Louis Academy of Medical and Surgical Sciences, November 30, 1897.

anemic, Gude's pepto-mangan was given in dessertspoonful doses, in milk, three times a day. She was also given an occasional saline purge. Patient's general health improved greatly. After several weeks of local treatment I found that the uterus had become freely movable, the inflammatory exudate in the pelvis had disappeared, and the uterus had regained its normal position, and I was now enabled to introduce a sound into the uterine cavity, which had been impossible prior to this time, owing to the pronounced flexion. The periodical hemorrhage still continued. So some days later, with the assistance of Dr. Lanphear, I thoroughly curetted the uterus, removing considerable fungoid material. The uterine cavity was irrigated with bichloride solution, and an iodoform gauze drain put in, which was removed in forty-eight hours. It is now seven weeks since the operation, and the patient is in perfect health, uterus is normal in size, normal in position, no discharge, no return of hemorrhage.

To my mind this case teaches us the beneficial results sometimes procured by conservative measures. I will admit that when I first examined this case my thoughts turned to surgical interference, thinking that it would be necessary to open the abdomen in order to liberate the uterus and correct the malposition, but my experience in this case and others of a like character has led me to believe that a great many such cases can be cured without subjecting a patient to such a formidable operation as abdominal section. Conservatism may lower the ambitious abdominal surgeon's record, but it will also lower the death rate. There is hardly a medical student in the country who is not desirous of becoming an abdominal surgeon, and when they are qualified they will be like that famous character in the "Kentucky Colonel" who was constantly thirsting for gore and asking for a chance to whittle on somebody's liver. This condition of affairs is largely due to the teachers of this branch of surgery, who are so anxious for clinical material to swell their operative records that many a section is made that is uncalled for. After a student has attended one course of lectures you cannot get him to speak on such ordinary topics as anatomy, physiology or chemistry, but he will give you a learned opinion on the disposal of the stump after the removal of an appendix, and other subjects of equal gravity, knowledge of which only comes from long training and experience. Therefore, I believe that students who are to become general practitioners should devote their energies to mastering general medicine and leave the abdominal work to men whose special training, skill and judgment best fit them for it.

The Oldest Medical Society in Illinois.—The Æsculapian Society of the Wabash Valley celebrated its fiftieth anniversary at Paris, Illinois, October 28, 1897. There were about seventy-five members of the profession in attendance. In the evening the local physicians gave a banquet, at which there was good music, appropriate speeches, and a good time generally. The society is in a most flourishing condition. The Æsculapian was organized in 1846, and hence has been in existence fifty-one years, but as it did not receive its charter until 1847; the year 1897 was celebrated as the fiftieth anniversary.

FORMULAE.

A Gargle for Lacunar Amygdalitis.—We find the following formula in the *Presse Medicale*:

℞ Beech creosote.....gtt. 8
Tinct. of myrrh.....
Glycerin.....aa gr. 900
Aq.....gr. 1800
M. —*N. Y. Med. Jour.*

Acute Coryza.—Capitan, in *Medicine Moderne*, recommends the following powder, which, he says, arrests generally, almost immediately, a commencing coryza; if, from the very onset, the patient takes pains to snuff up a pinch into each nostril and draw it in deeply:

℞ Saloli.....gr. 15
Acidi salicylici.....gr. 3
Acidi tannici.....gr. 1
Pulv. acidi borici..... $\bar{5}$ 1

M. Take a pinch every hour for half a day, and then discontinue the use of this snuff, for, if it be persevered with, it may cause an eczematous eruption on the margins of the nostrils, from the action of the phenic acid resulting from decomposition of the salol.

Another snuff-powder by the same writer is recommended as being similar in its action to the preceding, but less powerful:

℞ Pulv. cretæ.....gr. 75
Antipyrin.....gr. 16
Pulv. acidi borici.....gr. 30
Acidi salicylici.....gr. 4

M. This powder may be snuffed up the nostrils without fear of irritation.—*Ex.*

Sulphonal in the Treatment of Acute Mania.—Kadt (*Presse Medicale*) has had good results from the use of the following formula:

℞ Sulphonal.....gr. xv
Sodium bicarb.....gr. iv

M. For one cachet. From one to three such cachets are to be taken daily. In rebellious cases he gives much larger amounts—from sixty to seventy-five grains a day.—*Ex.*

Carbolic Acid Gangrene.—Leusser (*Muench Med. Woch.*) has observed gangrene of the finger-tips and portions of the skin in three cases after applications of strong solutions of carbolic acid. The laity and nurses show a marked ignorance and carelessness in the use of carbolic acid. From former observations it is evident that two per cent. solutions can produce gangrene if applied as a moist dressing and covered with gutta-percha. The author thinks it advisable to interdict its common sale.—*Ex.*

Chloasma.

℞ Ol. theobromæ.....
Ol. ricini.....aa $\bar{3}$ iiss
Zinci oxidi.....gr. ivss
Hydrarg. ammon.....gr. ij
Ol. rosæ, q. s.....

M. Sig.—Apply morning and evening.—*Moreir, Dom. Med. Mon.*

Mentholated Collodion in the Treatment of Contusions.—The *Journal de Medecine de Paris* attributes the following formula to Namé:

℞ Menthol.....parts iii-vj
Collodion.....parts xxiv-xxvij

M. Sig.—To be painted on once or twice a day. It is said to relieve the pain promptly and, by the contractile action of the collodion, to hasten the absorption of the effusion, provided it is not a joint that has been bruised.—*N. Y. Med. Jour.*

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RETROSPECTIVE.

In closing another year of journalistic work, we wish to acknowledge the receipt of many favors from our subscribers, collaborators, and advertisers. In spite of the fact that 1897 will go into history as a hard-times year, THE JOURNAL has had a remarkable growth, both as regards its subscription list and advertising patronage. We start the new year with a greater patronage than ever before. Much of our success has been due to the fact that we have had contributions from many of the leading medical authors of America and several in England. This policy of furnishing the best thoughts of the best men will be continued in 1898.

Attentive readers have noticed the efforts which have been made recently to bring about a better order of things in the profession. Many evils exist, some of which threaten the very life of the medical profession.

What We Are Fighting. These must be annihilated, and the outlook is that in the near future a better order of things will obtain. The abuse of medical charity by men and colleges which at one time stood high in professional circles has been exposed and to a certain extent checked. Reports made in local societies regarding the abuse of medical charity have been printed, and thousands of readers have become familiar with the situation. The efforts of the Saint Louis Academy of Medical and Surgical Sciences and of the Missouri Medical League have been presented in a forcible manner. We have been gratified by the support which has been given to THE JOURNAL, particu-

larly by the country doctors. They can rest assured that this publication will always be found on the side of the country doctor. It will jealously guard his rights, and will not hesitate to expose any and all who are inimical to his interests. Thanking each and every one for past favors, we are

Very truly yours,
THE EDITORS.

WHAT WILL BE THE FUTURE OF THE SAINT LOUIS MEDICAL SOCIETY?

Some of our readers will answer this question by saying: "D——n the Saint Louis Medical Society! Let it die." Others will sadly shake their heads and say: "Nobody knows."

After more than sixty years of life the society is practically dead. It owns no property. It has no home. Possibly it has not even a future. At no time in the last three months has its attendance been in excess of twenty members—members, not students and on-lookers.

When a society (whether medical or not) loses its own self-respect, it is doomed. When man after man declares that the Saint Louis Medical Society is a corpse, there must be a cause for the condition. It requires no great amount of intelligence to find many causes for the present state of dilapidation. The trouble with the society is that in its ranks are many who are "ethical quacks." They preach one thing and practice several different things. The society can have no assurance of success until after some of the barnacles have been removed. If the newspaper advertisers, ethical quacks, cheap-John doctors, abusers of medical charity and promoters of "fifty-cent hospitals" would only resign, the remaining members could reorganize the society, invite honorable men to membership, and move on to success. As matters are at present, a large attendance is never had except there be a fight on hand or a candidate is to be blackballed. Being members, we do not hesitate to speak plainly. Desperate conditions demand desperate remedies. Let something radical be done, and that quickly.

OUR INDEX.

Attention is called to the Index found in this issue. Inspection will show that we have had a rich supply of original articles. No other journal in this part of the country has compared to the TRI-STATE in this respect. It is a fact that able authors are always willing to write for us. They like to see their productions placed before their readers in an attractive form. The coming year will witness an increase in this department.

THE INDIAN TERRITORY MEDICAL SOCIETY.

We recently attended the Indian Territory Medical Society at Muskogee. This society is composed of the cream of the medical profession of the Territory. In all respects it will compare favorably with similar bodies in the States. The Indian country has many able physicians and surgeons—men who use all the modern aids to diagnosis and do their work properly. Educated physicians are the rule and ignorant ones the exception, because of local laws. No one can practice medicine in the Territory until he has passed an examination before a board of medical examiners. Think of that, ye dissatisfied who live in the "great State of Mizzoury," where osteopathy raises its head in brazen effrontery! There

are no medical schools in the Territory, and few hospitals; consequently, it is a good place in which to practice medicine.

The Indian Territory doctors are all right. That they are "friendly Indians" is evidenced by the fact that they adopted *THE JOURNAL* as their official organ. Before doing so they wanted to know our attitude on some of the burning questions of the day—as "fifty-cent hospitals," the abuse of free clinics, and other evils.

CLINICAL LECTURE BY DELAFIELD.

Our next number will contain a clinical lecture by Professor Francis Delafield, attending physician to the Roosevelt Hospital, New York. It is our intention to present, each month of 1898, a clinical lecture by some eminent physician. Most medical journals have more surgical than medical articles. We shall give more attention to the medical subjects than ever before. Having a special reporter on the field, we can command the best that New York affords in the way of clinical teaching. Professor Delafield's lecture deals with nephritis, colitis, and exophthalmic goiter: all practical subjects.

THE "ALKALOIDAL CLINIC."

One of our most valued exchanges is the *Alkaloidal Clinic*, of Chicago. To help rescue therapeutics from its bitter enemies, nihilism and polypharmacy, is the mission of our energetic contemporary, the *Alkaloidal Clinic*. The certainty and efficiency of alkaloidal medication marks a most important improvement in the old methods, and the *Clinic* worthily presents the method.

Under the energetic direction of Dr. Abbott and the able editorial management of Dr. Waugh, its many contributors serve up monthly to its readers a feast of good things. We advise and earnestly urge our subscribers to add the *Clinic* to their list of journals for the coming year.

Taka-Diastase is now marketed in three forms—in powder, in $\frac{1}{4}$, $\frac{1}{2}$ and 1 ounce vials; capsules, $2\frac{1}{2}$ grains each; in bottles of 25, 100 and 500; and liquid taka-diastase, 8-ounce bottles only, 2 grains of the ferment to each fluid drachm.

In a recent circular Messrs. Parke, Davis & Company state: "We have introduced liquid taka-diastase to meet the demands of those who object to both powders and capsules. In order to satisfy such patients, we know of several instances where solutions have been prepared extemporaneously, but with medicaments or vehicles with which taka-diastase is incompatible. Of course, failure in such instances was unjustly attributed to taka-diastase. Liquid taka-diastase will in future, however, most satisfactorily take care of all such cases.

"Under no circumstances should taka-diastase be massed. It should be administered either in powders, in capsules, or the liquid form, and during or immediately after meals."

If not already familiar with taka-diastase, write the manufacturers at once for monographs, reports of cases, reprints of articles, etc. Taka-diastase is certainly *the* remedy in amylaceous dyspepsia.



DR. A. H. OHMANN DUMESNIL.
President of the St. Louis Academy of Medical and Surgical Sciences.

ABSTRACTS.

Disinfection by Formaldehyde Vapor.—If one may trust the reports of careful observers in Europe and America, and may judge from a limited personal experience unchecked by laboratory investigations, the problem of disinfection of apartments and their contents, during and after their occupancy by patients having contagious diseases, has at length been solved. Dr. Hans Aronson (*Zeitschrift fuer Hygiene und Infectious Krankheiten*, Vol. XXV., June, 1897) summarizes investigations to date upon the antiseptic properties of formaldehyde, and recounts new experiments tending to confirm his original researches. Various methods of disinfection by utilizing the penetrating powers of formaldehyde gas upon a large scale have been proposed. Aronson finds most of them objectionable, including in this category all attempts at vaporization by means of heat from commercial solutions of formaldehyde in water, or from solutions in methylated alcohol, and attempts to develop the gas directly by heat applied to wood alcohol in lamps of various devices.

Of all methods, he prefers that of Schering, which utilizes the solid polymerized formaldehyde (paraformaldehyde or paraform) in the shape of pastils weighing one gramme each. These being exposed to heat in lamps of proper construction, the heated gases of combustion convert the paraformaldehyde again into formaldehyde gas, which becomes thoroughly mixed with them, and with them is distributed into all portions of the place to be-disinfected, the necessary moisture being likewise supplied by the combustion. In a room of about 100 cubic meters (3,500 cubic feet) contents (25 feet x 13 feet x 10 $\frac{3}{4}$ feet), he placed test objects at different levels. The microbes used were staphylococcus, streptococcus, bacillus pyocyaneus, typhoid, diphtheria and tubercle bacilli, and anthrax spores. It was found that one lamp containing 100 pastils (one pastil per cubic meter—35 cubic feet) was sufficient to destroy all germs but anthrax spores; for this, 200 pastils sufficed.

It made no difference where the test objects were placed or through how many thicknesses of material the vapor had to penetrate. Even the scrapings of dust were sterile. The necessary number of pastils was placed in the apparatus, the lamp lighted, and the room closed for twenty-four hours. A strong odor of formaldehyde perceived on entering, was quickly dissipated by opening the windows.

In cases of diphtheria and scarlet fever we have had the small lamp with a single pastil used continuously, while likewise vaporizing a mixture of turpentine and eucalyptol, or the latter alone, for the sake of the odor as well as for the undoubted therapeutic usefulness of the latter mixture.—*Philadelphia Polyclinic*.

Hydrozone for Disorders of the Genito-Urinary Tract.—Dr. John Aulde, of Philadelphia (*Medical Times and Register of Philadelphia, Pa.*, Dec. 5, 1896), states that about eight years ago he was forcibly impressed with the value of peroxide of hydrogen in a protracted case of gonorrhœa. The disease had persisted for three months despite the treatment of several

attendants, there being a constant discharge and in addition, there was an orchitis present, the left testicle being about as large as a base-ball. Treatment consisted of the local use of injections of equal parts of peroxide of hydrogen and moderately warm water, used at intervals of four hours, these injections being followed by a solution of arsenite of copper containing one milligram (one 65th grain) to the drachm, diluted with an equal quantity of hot water.

In a week the patient was able to return to his home in a distant State, the discharge from the urethra having entirely ceased, and pain and chordee having disappeared.

The author advises the same treatment for non-specific urethritis and gleet, but as hydrozone is much stronger (two times) than the peroxide, and perfectly harmless, he gives it the preference.

In vaginitis and vaginismus this treatment is of especial value. The treatment heretofore recommended by physicians, consisting of hot vaginal douches, either with or without some alkali, as sodium bicarbonate, followed by the injection of a small quantity of peroxide of hydrogen (medicinal) in warm or cold water is superseded by the single application of a hot solution of hydrozone, one part in eight; the patient should use a fountain syringe which should be hung upon the wall about six feet from the floor; the patient sits upon a suitable vessel, and introduces the rubber tip of the hose well back into the vagina, while the labia are compressed by the disengaged hand; this allows the solution to so distend the vagina as to bring it in contact with all the diseased tissue. The injection should be repeated twice in twenty-four hours.

In uterine diseases, where the solution must be brought into contact with the endometrium, the following treatment is pursued:

The patient is placed in the dorsal position, with the hips well elevated; an ordinary dilator is employed to distend the cervix, so as to admit the nozzle of the syringe and permit the free egress of the injected fluid (a suitable return-flow tube can be used to better advantage, the Fritsche's douche is the best that can be used). The injection is then made, a liberal amount of the hot medicated solution being used.

There is need of caution in chronic cases, that the effervescence which attends the destruction of the unhealthy tissue does not force some of the débris into the Fallopian tubes. This is best avoided by using a large quantity of the solution, and afterwards directing the patient to assume the upright position. The pressure thus brought to bear upon the uterus will cause the complete discharge of all débris.

A preliminary vaginal douche should always be taken, using the medicated solution, as otherwise harm might ensue by the entrance into the uterus of the vaginal secretions. The author warns against the use of the vaginal douche if the cervix be patulous, as there is an almost certain danger of the infected vaginal débris being forced into the uterine cavity. To avoid this the vagina should be cleansed by the local use of the medicated solution through the speculum.

The author believes hydrozone to be the best remedy for cystitis occurring either in the male or female. The bladder should be washed out with the solution (one to eight) a small quantity being used at first in chronic cases, owing to the painful muscular contractions following the withdrawal of the solution. The amount can be gradually increased.

(A double current hard rubber catheter should always be used for that purpose.) In gonorrhœa, gleet, and cystitis, the local treatment is oftentimes aided by the internal administration of hourly doses of calcium sulphide, one-tenth of a grain.

Registration of Non-Graduates in Illinois.—At the regular quarterly meeting of the Illinois State Board of Health, held at the Great Northern Hotel, Chicago, October 5, 1897, the following resolutions were passed:

Resolved, That after May 1, 1898, all non-graduate applicants for license to practice medicine and surgery, who are examined in accordance with the provisions of the Medical Practice Act, in addition to the requirements already exacted, must present as evidence of a satisfactory preliminary education, either:

1. A diploma or certificate of graduation from a high school.
2. A certificate of having passed the matriculation examination to a recognized literary or scientific college.
3. A certificate of successful examination by the faculty of any reputable university or college of arts or science (not members of a medical college faculty), by the State Superintendent of Public Instruction of Illinois, or by the principal of a high school in Illinois, in the following branches: English Grammar, Arithmetic, Elementary Physics, United States History, Geography and Latin (equivalent to one year in a high school).

Each candidate will also be required to present a certificate from a medical college in good standing with this board, attesting that the applicant has:

1. Pursued the study of practical anatomy in said college for at least one term and has made dissections of the entire cadaver.
2. Taken at least one full course in operative surgery and practical obstetrics.
3. Personally attended six or more cases of labor.

Bacteriology has been added to the subjects of the non-graduate examination.

Epidermolysis Bullosa Acquisita.—Under this title Dr. A. H. Ohmann-Dumesnil, of St. Louis, describes (*St. Louis Med. and Surg. Jour.*, October 17th) a rare affection of the skin. It consists of a process which manifests itself in the formation of bullæ, together with a lysis or solution of certain parts of the epidermis, whereby this layer easily separates from those which underlie it. The trouble is a comparatively unusual one, and all the cases which have been published and identified since 1879 number about forty. In all of these the affection is said to be congenital. The peculiarity observed is that the manifestations of the trouble occurred a short time after birth, and manifested themselves from time to time. A slight pressure upon the skin was sufficient to cause the trouble. Heredity was apparently present, as it was traced for as many as four generations back. In all cases the nails were affected, and the mucosa of the mouth was found to suffer in some patients. All the patients observed seemed to enjoy good health. Quite a detailed account of the published cases, including his own, is given by Wallace Beatty, M. D., in the *British Journal of Dermatology* for August, 1897, together with a good clinical

description of his cases and the histo-pathology, as determined by him, to which I would refer those particularly interested in the subject.

I propose to describe a case of epidermolysis bullosa, which differs, however, in some particulars from all those which have been hitherto reported:

CASE.—Mr. S——, of German descent, aged about thirty-six, came to see me for a chronic thickening and blood stasis at the point of his right elbow. He is a very stout man, dark-haired and dark-eyed, and rather quick in his movements. He is engaged in book-keeping, but takes exercise. He has never had syphilis. In fact, his general health has always been good. When he applied for treatment I prescribed an ointment of iodoformin, one drachm to an ounce of cold cream. In two days he presented the symptoms which I shall describe further on. When the appearance to be described manifested itself, I elicited the history that he had already suffered from the same trouble twice previously. Some two years before he had a small ulcer on the inner side of his right knee, and a physician dressed it with iodoform and a bandage. In thirty hours bullæ appeared and the epidermis began separating. One year ago he had a chafe and exoriation of the right side of the chin, and was given an ointment composed of one drachm of compound tincture of iodine to an ounce of simple cerate. In about two days bullæ appeared and the epidermis separated.

After hearing this history, I concluded that this patient had an idiosyncrasy in respect to iodine preparations applied externally. This manifested itself in a peculiar manner, so far as the attack I could observe was concerned. A number of bullæ formed about the elbow-joint and in a fold of the elbow, varying in size from a small bird-shot to the thumb-nail. The walls were rather tense, the contents being straw-colored, but having no pus whatever in them. The skin between the bullæ was somewhat erythematous, but no areola existed around the blebs. Examination of the serum for iodine was negative. The skin in general was not tender, and it was the appearance and exudation which seemed to bother the patient most. This exudation was most profuse, and was not only derived from the blebs, but from the surface left exposed by the displaced epidermis. In some places the floor of the bulla bled after its walls had been split and it was removed.

The treatment in this case was the application of protective measures at first. Campho-phénique powder was liberally dusted on, gauze placed over this, then absorbent cotton and rubber tissue. In a couple of days liquid campho-phénique, campho-phénique gauze and a roller bandage was applied twice a day, and a rapid recovery followed. There never was even so much as a drop of pus. Such is a bare outline of the case I have to report. Some of the peculiarities to notice are as follows:

The coincidence that it always was the right side which was affected.

The nails were not affected at all.

The trouble was not congenital.

It was not a dermatitis, properly so-called.

It was not caused by pressure or trauma.

Each attack was due to the external use of some iodine derivative.





